

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7262

CERTIFICATE OF DEATH

Reg. Dist. No.

07173

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>8 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ireland Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Bailey</u> Last <u>Bailey</u>		4. DATE OF DEATH <u>June 11</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years Day Month Min. <u>70</u> yrs. <u>10</u> months <u>11</u> days <u>19</u> min.)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>hosp. records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>and Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 13</u> , 19 <u>60</u> , to <u>June 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theo. Zegarra M.D.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Theodore Zegarra, M.D. Riverdale, P. G., Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 14 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Culpeper Fairview</u>	22d. LOCATION (City, town, or county) (State) <u>Pr</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Joseph Sosa</u> ADDRESS <u>Hyattsville Md</u>		24a. REC'D BY REGISTRAR <u>JUN 14 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Charles L. Knaus</u>

CERTIFICATE OF DEATH

1962

(M)

42

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH March 24, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SOCIAL SECURITY NUMBER [REDACTED]		17. RACE White		18. COLOR White	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF WITNESS [Signature]		21. SIGNATURE OF PHYSICIAN [Signature]	
22. SIGNATURE OF CORONER [Signature]		23. SIGNATURE OF JURY [Signature]		24. SIGNATURE OF JUDGE [Signature]	
25. SIGNATURE OF DISTRICT ATTORNEY [Signature]		26. SIGNATURE OF PROSECUTOR [Signature]		27. SIGNATURE OF DEFENSE ATTORNEY [Signature]	
28. SIGNATURE OF JAILER [Signature]		29. SIGNATURE OF CHIEF OF POLICE [Signature]		30. SIGNATURE OF SHERIFF [Signature]	
31. SIGNATURE OF CLERK [Signature]		32. SIGNATURE OF RECORDER [Signature]		33. SIGNATURE OF INDEXER [Signature]	
34. SIGNATURE OF FILE CLERK [Signature]		35. SIGNATURE OF ARCHIVIST [Signature]		36. SIGNATURE OF LIBRARIAN [Signature]	
37. SIGNATURE OF CURATOR [Signature]		38. SIGNATURE OF HISTORIAN [Signature]		39. SIGNATURE OF RESEARCHER [Signature]	
40. SIGNATURE OF ASSISTANT RESEARCHER [Signature]		41. SIGNATURE OF CLERICAL ASSISTANT [Signature]		42. SIGNATURE OF JANITOR [Signature]	
43. SIGNATURE OF NIGHT WATCHMAN [Signature]		44. SIGNATURE OF GARDENER [Signature]		45. SIGNATURE OF COOK [Signature]	
46. SIGNATURE OF BUTLER [Signature]		47. SIGNATURE OF HOUSEKEEPER [Signature]		48. SIGNATURE OF MAINTENANCE [Signature]	
49. SIGNATURE OF ELECTRICIAN [Signature]		50. SIGNATURE OF PLUMBER [Signature]		51. SIGNATURE OF CARPENTER [Signature]	
52. SIGNATURE OF PAINTER [Signature]		53. SIGNATURE OF ROOFER [Signature]		54. SIGNATURE OF TILER [Signature]	
55. SIGNATURE OF GLAZIER [Signature]		56. SIGNATURE OF JOINER [Signature]		57. SIGNATURE OF MILLWRIGHT [Signature]	
58. SIGNATURE OF BLACKSMITH [Signature]		59. SIGNATURE OF WHEELWRIGHT [Signature]		60. SIGNATURE OF COBBLER [Signature]	
61. SIGNATURE OF HATMAKER [Signature]		62. SIGNATURE OF SHOE REPAIRER [Signature]		63. SIGNATURE OF JEWELER [Signature]	
64. SIGNATURE OF OPTICIAN [Signature]		65. SIGNATURE OF BARBER [Signature]		66. SIGNATURE OF HAIR DRESSER [Signature]	
67. SIGNATURE OF BEAUTICIAN [Signature]		68. SIGNATURE OF NAIL TECHNICIAN [Signature]		69. SIGNATURE OF MASSAGE THERAPIST [Signature]	
70. SIGNATURE OF CHIROPRACTOR [Signature]		71. SIGNATURE OF YOGI [Signature]		72. SIGNATURE OF MEDITATION INSTRUCTOR [Signature]	
73. SIGNATURE OF MEDITATION STUDENT [Signature]		74. SIGNATURE OF MEDITATION TEACHER [Signature]		75. SIGNATURE OF MEDITATION MASTER [Signature]	
76. SIGNATURE OF MEDITATION MENTOR [Signature]		77. SIGNATURE OF MEDITATION MENTEE [Signature]		78. SIGNATURE OF MEDITATION MENTOR [Signature]	
79. SIGNATURE OF MEDITATION MENTEE [Signature]		80. SIGNATURE OF MEDITATION MENTOR [Signature]		81. SIGNATURE OF MEDITATION MENTEE [Signature]	
82. SIGNATURE OF MEDITATION MENTOR [Signature]		83. SIGNATURE OF MEDITATION MENTEE [Signature]		84. SIGNATURE OF MEDITATION MENTOR [Signature]	
85. SIGNATURE OF MEDITATION MENTEE [Signature]		86. SIGNATURE OF MEDITATION MENTOR [Signature]		87. SIGNATURE OF MEDITATION MENTEE [Signature]	
88. SIGNATURE OF MEDITATION MENTOR [Signature]		89. SIGNATURE OF MEDITATION MENTEE [Signature]		90. SIGNATURE OF MEDITATION MENTOR [Signature]	
91. SIGNATURE OF MEDITATION MENTEE [Signature]		92. SIGNATURE OF MEDITATION MENTOR [Signature]		93. SIGNATURE OF MEDITATION MENTEE [Signature]	
94. SIGNATURE OF MEDITATION MENTOR [Signature]		95. SIGNATURE OF MEDITATION MENTEE [Signature]		96. SIGNATURE OF MEDITATION MENTOR [Signature]	
97. SIGNATURE OF MEDITATION MENTEE [Signature]		98. SIGNATURE OF MEDITATION MENTOR [Signature]		99. SIGNATURE OF MEDITATION MENTEE [Signature]	
100. SIGNATURE OF MEDITATION MENTOR [Signature]		101. SIGNATURE OF MEDITATION MENTEE [Signature]		102. SIGNATURE OF MEDITATION MENTOR [Signature]	

RECEIVED
MAY 10 1968
BALTIMORE
STATE DEPARTMENT OF HEALTH

1
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7203

CERTIFICATE OF DEATH

Reg. Dist. No.

07174

1. PLACE OF DEATH o. COUNTY Princes Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 70 College Park	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael First Joseph Middle William Last Robert Baker 111		4. DATE OF DEATH Month June Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/60
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Baker Jr.		14. MOTHER'S MAIDEN NAME Mildred C. Dement	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 pulmonary embolism DUE TO idiopathic pulmonary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) idiopathic pulmonary DUE TO embolism (c) embolism		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13 , 19 60 , to June 15 , 19 60 that I last saw the deceased alive on June 15 , 19 60 , and that death occurred at 6:30 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		ADDRESS (Street, city or town, state) 6905 Baltimore Ave. DATE SIGNED 6/16/60	
PHYSICIAN'S NAME (Type) Thomas A. Christensen		College Park, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/60	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 1960	
24b. REGISTRAR'S SIGNATURE Arthur L. Brown			

70

1. 1911

CERTIFICATE OF DEATH

Reg. Dist. No.

07175

7204

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James E Baldwin		4. DATE OF DEATH June 20 19 60	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-12
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Trailer Truck	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James B Baldwin		14. MOTHER'S MAIDEN NAME Annie E Soper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Annie E Baldwin		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-20 1960 to 6-20 1960 , that I last saw the deceased alive on 6-20 1960 , and that death occurred at 7:30pm from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Wollcot L. Etienne MD.		ADDRESS (Street, city or town, state) 4713 - Berwyn St College Park, Md. DATE SIGNED 6/20/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR JUN 24 1960		24b. REGISTRAR'S SIGNATURE James E. Baldwin	

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CERTIFICATE OF DEATH

Reg. Dist. No.

07176

7268

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CAMP SPRINGS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
c. LENGTH OF STAY IN 1b <u>70 minutes</u>				d. STREET ADDRESS <u>4530 FAIRFAX ROAD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHERYL ANN BARNES</u>				4. DATE OF DEATH Month Day Year <u>JUNE 25 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGROID</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 JUNE 60</u>	9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>EUGENE W. BARNES, JR.</u>				14. MOTHER'S MAIDEN NAME <u>PATRICIA A. BARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>FATHER - ITEM 13</u>		Address <u>4530 FAIRFAX ROAD, BALTIMORE 16, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis, congenital</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>70 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>25 June, 1960</u> , to <u>25 June, 1960</u> , that I last saw the deceased alive on <u>25 June, 1960</u> , and that death occurred at <u>2215</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MD.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>John A. Moore</u> M.D. <u>USAF HOSPITAL ANDREWS, 25 JUNE 60</u> PHYSICIAN'S NAME (Type) <u>JOHN A. MOORE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. F. Taylor</u> ADDRESS <u>909 6th St N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2050221XV4

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1885		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. DATE OF DEATH 1950		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF DECEASED James H. Brown		17. SIGNATURE OF WITNESS John Doe		18. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		19. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		20. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe	
21. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		22. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		23. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		25. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
26. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		27. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		28. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		29. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		30. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
31. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		32. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		33. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		34. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		35. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
36. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		37. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		38. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		39. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		40. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
41. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		42. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		43. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		44. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		45. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
46. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		47. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		48. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		49. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		50. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
51. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		52. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		53. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		54. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		55. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
56. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		57. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		58. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		59. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		60. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
61. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		62. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		63. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		64. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		65. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
66. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		67. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		68. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		69. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		70. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
71. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		72. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		73. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		74. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		75. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
76. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		77. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		78. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		79. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		80. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
81. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		82. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		83. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		84. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		85. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
86. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		87. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		88. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		89. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		90. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
91. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		92. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		93. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		94. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		95. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
96. SIGNATURE OF DECEASED'S NEAREST RELATIVE John Doe		97. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith		98. SIGNATURE OF DECEASED'S MINISTER Rev. John Doe		99. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Brown		100. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14, 22 Film G269 6-17-60 et

CERTIFICATE OF DEATH

07177

Reg. Dist. No.

7269

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>CHARLES</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANDREWS AFB</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF Hosp Andrews-</i>				e. IS RESIDENCE ON A FARM? <i>NO</i>			
3. NAME OF DECEASED (Type or print) <i>Baby Boy- BENTON</i>				4. DATE OF DEATH <i>June 4 1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3 June 60</i>	9. AGE (In years last birthday) <i>- yrs.</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>10</i> Hours <i>43</i>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Floyd G. Benton</i>				14. MOTHER'S MAIDEN NAME <i>Betty L. Wilcox</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp chart.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO <i>776X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>776X</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>0800 4 June 1960</i> , to <i>2000 4 June 1960</i> , that I last saw the deceased alive on <i>8:12 PM, 19 60</i> , and that death occurred at <i>8:10 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Salvatore Battiatto</i> M.D.				ADDRESS (Street, city or town, state) <i>USAF Hosp Andrews</i> DATE SIGNED <i>4-6-60</i>			
PHYSICIAN'S NAME (Type) <i>SALVATORE BATTIATA, CAPT USAF MC ANDREWS AIR FORCE BASE, WASHINGTON 25 DC</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6-6-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>D. C. Morgue</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Andrews Air Force Base</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>JUN 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050202XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07178

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 7979 Walker Mill Road	
3. NAME OF DECEASED (Type or print) First Alfred Middle Berry Last		4. DATE OF DEATH Month June Day 26 Year 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-16
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington Berry		14. MOTHER'S MAIDEN NAME Rebecca Dunnington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Matilda Berry; same address as #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 421.4 DUE TO Chronic valvular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 26, 1960			
22a. BURIAL CREMATION, REMOVAL (Specify) 6-30-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St Marys Ch. Cemetery		22d. LOCATION (City, town, or county) (State) Croome Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.S. Washington</i>		ADDRESS 4925 Deane Ave N.E.	
24a. REC'D BY REGISTRAR DATE JUN 29 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switzland</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Switzland Nursing Home</u>				d. STREET ADDRESS <u>13220 Chillum Rd. #202</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>J.</u> Last <u>BEVANS</u>				4. DATE OF DEATH Month <u>6-</u> Day <u>12-</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-86</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maids</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Willard Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Bevans</u>				14. MOTHER'S MAIDEN NAME <u>May S. Ashford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-22-2407</u>		17. INFORMANT <u>Ruby Burger 2220-Que St. S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral thrombosis with</u> DUE TO <u>Left hemiplegia</u> (c) <u>Congestive Heart Failure</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 weeks</u> <u>6 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-1-</u> , 19 <u>60</u> , to <u>6-12-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-12-</u> , 19 <u>60</u> , and that death occurred at <u>4:07 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>6-12-60</u>							
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D.				PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON</u> <u>5731-23rd Parkway Hillcrest Heights Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber G. Inc.</u> ADDRESS <u>517-11th St. S.E.</u>				24a. REC'D BY REGISTRAR <u>DAVID 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1230

48

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PRESENT ADDRESS</p> <p>12. DATE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. CAUSE OF DEATH</p> <p>15. MANNER OF DEATH</p> <p>16. SIGNATURE OF PHYSICIAN</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF NEXT OF KIN</p> <p>21. SIGNATURE OF BURIAL OFFICIAL</p> <p>22. SIGNATURE OF FUNERAL HOME</p> <p>23. SIGNATURE OF CHURCH</p> <p>24. SIGNATURE OF CEMETERY</p> <p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF PHYSICIAN</p> <p>27. SIGNATURE OF REGISTRAR</p> <p>28. SIGNATURE OF WITNESSES</p> <p>29. SIGNATURE OF DECEASED</p> <p>30. SIGNATURE OF NEXT OF KIN</p> <p>31. SIGNATURE OF BURIAL OFFICIAL</p> <p>32. SIGNATURE OF FUNERAL HOME</p> <p>33. SIGNATURE OF CHURCH</p> <p>34. SIGNATURE OF CEMETERY</p> <p>35. SIGNATURE OF OTHER</p>
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07180

CERTIFICATE OF DEATH

Reg. Dist. No.

7194

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>60</u> <u>HYATTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5825 32ND AVE</u>				e. STREET ADDRESS <u>5825 32ND AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Veronica</u> Last <u>Blake</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 12, 1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PHILA. PENN'A.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH McDONALD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>209-26-8967</u>		17. INFORMANT <u>MICHAEL H. BLAKE</u> Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon (rectum)</u> 31 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 18</u> 19 <u>60</u> , to <u>June 22</u> 19 <u>60</u> , that I lost s/he the deceased on <u>June 7</u> 19 <u>60</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Leonard Gold</u> M.D.				ADDRESS (Street, city or town, state) <u>8641 Colesville Road</u> DATE SIGNED <u>6/22/60</u>			
PHYSICIAN'S NAME (Type) <u>G. LEONARD GOLD</u>				Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Eco. Riverdale, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

06

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		Male		35		Jan 5, 1928		Memphis, Tenn.		None		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
Jan 4, 1968		10:00 AM		St. Louis, Mo.		Suicide		Natural		[Signature]		[Signature]		[Signature]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESSES		20. FULL NAME OF DECEASED'S NEXT OF KIN		21. FULL NAME OF DECEASED'S CEMETERY		22. FULL NAME OF DECEASED'S FUNERAL HOME		23. FULL NAME OF DECEASED'S BURIAL PLACE		24. FULL NAME OF DECEASED'S INTERMENT PLACE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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1 FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07181

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Princess Delle Burroughs				4. DATE OF DEATH June 25, 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-1900	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE (In years last birthday) 60 yrs.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Fred. Burroughs, same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 816 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the skull DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compound fractures of both distal end of femurs							
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) MV - MV			
20c. TIME OF INJURY Month, Day, Year 7:00 p.m. 6/25/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road		20f. (City or town) (County) (State) Forestville P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 6/26/60				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-29-60				22b. DATE THEREOF 6-29-60			
22c. NAME OF CEMETERY OR CREMATORY St. Joseph Catholic Church				22d. LOCATION (City, town, or country) (State) Pomfret, Charles C. Md.			
23. FUNERAL DIRECTOR Myrtle K. Rollins				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			
24a. REGISTRAR'S NAME Rollins				24c. DATE JUN 29 '60			

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Primo Caracciolo

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Exhibit 101 of 101

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2. Mrs. I. B. Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07182

7207

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45 North Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Byrd Last Byrd				4. DATE OF DEATH Month June Day 13 Year 1960			
5. SEX F	6. COLOR OR RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1913		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 47 Days 13 Hours 13 Min.	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Mary B. Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Husband - Clyde Byrd		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 4 hrs 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost the deceased alive on 19 , and that death occurred at 19 M, from the causes and on the date stated above.							
22a. SIGNATURE Norman Donat Borneau M.D.				22b. DATE SIGNED 6/13/60		22c. PHYSICIAN'S NAME (Type) NORMAN DONAT BORNEAU	
22d. ADDRESS 3503 Penny St Mt Rainier Md				22e. ADDRESS —			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-16-60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery, B.C.		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Leroy C. Berry Huntingtown, Md.				25a. REC'D BY REGISTRAR JUN 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

Released by Dr. J. MALONEY, COLEMAN, Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

43

CERTIFICATE OF DEATH

South Woodstock

1881

April 9, 1913

John W. Smith

1881-1913

07123

1881-1913

1881-1913

1881-1913

John W. Smith

1881-1913

7271

CERTIFICATE OF DEATH

Reg. Dist. No. 07183

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 1440</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Boulevard 1440</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>14905 Byrd St. S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Estherine</u> Middle <u>K.</u> Last <u>CAHODA</u>				4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
13. FATHER'S NAME <u>John Kramer</u>				14. MOTHER'S MAIDEN NAME <u>Goodie Kramer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Seline Cahoda</u> Address <u>4905 Byrd St. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerotic Hypertensive C. V. Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 months</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osteoarthritis</u> <u>Chronic Lung Disease</u> <u>1957 Radical Mastectomy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>60</u> , to <u>6-21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>60</u> , and that death occurred at <u>1:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Calarco</u>				ADDRESS (Street, city or town, state) <u>3801 S. Highland Rd. S.E.</u>			
DATE SIGNED <u>6-21-60</u>							
PHYSICIAN'S NAME (Type) <u>John J. Calarco M.D.</u>				<u>Washington 20, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE OF REMOVAL (Specify) <u>6/1/60</u>		22c. NAME OF CEMETERY OR CREMATOR <u>GEO. WASH. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Collegiate Funeral Home</u>				ADDRESS <u>4217-9th St NW</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>JUN 22 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07184
Reg. Dist. No.

7203		7203	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45 N. Brentwood	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 4552 41st Avenue	
3. NAME OF DECEASED (Type or print) First Alice Middle Marie Last Campbell		4. DATE OF DEATH Month June Day 5 Year 19 60	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1915
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Cooper	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Clarence V. Campbell; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Stab wound of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed in chest by another person. Operation. Expired on table	
20c. TIME OF INJURY Month, Day, Year 8:45 p.m. 6-4-60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Home. Out doors. Brentwood, Pr. Geo. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input checked="" type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6.9.60	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Smith</i>		24. REC'D BY REGISTRAR JUN 7 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>		24c. DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial, cremation, or removal.

AND STATE DEPARTMENT OF HEALTH - ALBANY 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES GEORGE		Male		30	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1918		New York City		Disease of the heart	
TIME OF DEATH		MANNER OF DEATH		LOCALITY OF DEATH	
10:00 AM		Natural		New York City	
DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF BURIAL	
1918		New York City		Disease of the heart	
TIME OF BURIAL		MANNER OF BURIAL		LOCALITY OF BURIAL	
10:00 AM		Natural		New York City	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF EXAMINATION	
1918		New York City		Disease of the heart	
TIME OF EXAMINATION		MANNER OF EXAMINATION		LOCALITY OF EXAMINATION	
10:00 AM		Natural		New York City	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF SIGNATURE	
1918		New York City		Disease of the heart	
TIME OF SIGNATURE		MANNER OF SIGNATURE		LOCALITY OF SIGNATURE	
10:00 AM		Natural		New York City	

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may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7209

Item 9 Film Q266 7/5/60 iwk

CERTIFICATE OF DEATH

07185

1. PLACE OF DEATH a. COUNTY Prince Georges Samuel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle W Last Carter		4. DATE OF DEATH Month June Day 26 Year 19 60	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Aug. 1898
9. AGE (In years last birthday) 61 62 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Louise Carter		Address Wesley St. Glen Arden Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hemorrhage left internal capsule DUE TO (c) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 26 June 19 60 to 26 June 19 60 that (I) (we) last saw the deceased alive on 26 June 19 60 , and that death occurred on 26 June 19 60 , from the causes and on the date stated above.			
22a. PHYSICIAN'S SIGNATURE George Hageage		22b. DATE SIGNED 6-26-60	
22c. PHYSICIAN'S NAME (Type) Dr. Geo. Hageage., M.D.		22d. ADDRESS Mt. Rainier., Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-29-60		23b. DATE THEREOF 6-29-60	
23c. NAME OF CEMETERY OR CREMATORY Holy Family Cem.		23d. LOCATION (City, town, or county) (State) Woodmore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington Sons		25a. REC'D BY REGISTRAR ONE	
25b. REGISTRAR'S SIGNATURE ONE		DATE JUN 29 1960	

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1-1-1944

1-1-1944

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7272

CERTIFICATE OF DEATH

Reg. Dist. No.

07186

1. PLACE OF DEATH o. COUNTY <u>PR. Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington DC</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN lb <u>9 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FORESTVILLE NURSING HOME-2118-15 St S.E.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>M.</u> Last <u>CASSADAY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1st</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27-1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Clifton Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James C. Kincheloe</u>				14. MOTHER'S MAIDEN NAME <u>Jessanna Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, or, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>J. Gordon Kincheloe</u>		INFORMANT Address <u>Fairfax Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis 5yr</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>42</u> , to <u>6-1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-31-60</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2210 Madison Ave SE Wash DC</u> DATE SIGNED							
ACTUAL SIGNATURE <u>John B Fegan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JOHN B FEGAN</u>				<u>2210 Madison Ave SE Wash DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 3-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Clifton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clifton Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS</u>				23a. RECEIVED BY REGISTRAR <u>1001 Good Hope</u>		23b. REGISTRAR'S SIGNATURE <u>Wm. R. ROSE</u>	
				DATE <u>JUN 6 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7210

CERTIFICATE OF DEATH

07187

1. PLACE OF DEATH a. COUNTY Princes Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 68 Berwyn Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 8911 59th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kevin Paul Cavalin				4. DATE OF DEATH Month June Day 11 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1959	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Vincenzo G. Cavalin				14. MOTHER'S MAIDEN NAME Elenore I. Rolfsema			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Father				Address Md. 8911 59th Ave., Berwyn Heights,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) Interstial pneumonia DUE TO Cong. Hh. Db. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from June 1959 to June 1960 , that (I) (we) last saw the deceased alive on June 6 1960 , and that death occurred 10:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Hans Wodak				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Hans Wodak				22d. ADDRESS 30 C Ridge Road, Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 6/13 /60			
23c. NAME OF FUNERAL HOME 7 Guicke Sons Hyattsville Md				23d. ADDRESS 7 Guicke Sons Hyattsville Md			
24. FUNERAL DIRECTOR'S SIGNATURE 7 Guicke Sons Hyattsville Md				25a. RECEIVED BY REGISTRAR DATE JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

68

7310

CERTIFICATE OF DEATH

02110

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

7273

CERTIFICATE OF DEATH

Reg. Dist. 07188

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Bowie)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home (Bowie Md.)</u>				d. STREET ADDRESS <u>Bowie Md</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Chittams</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Employee Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Contee</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Chittams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>		17. INFORMANT <u>John Aubrey Brown</u> Address <u>Bowie Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Illnesses Incident to Old Age</u> 794X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>60</u> to <u>June 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry A. Wise Jr.</u> M.D. <u>149 9th St Bowie Md</u>				ADDRESS (Street, city or town, state) <u>6/17/60</u> DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u> <u>149 9th St Bowie, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>6-21-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aurison Church</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington</u> ADDRESS <u>4925-Deane Ave NE</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1971

[Faint, mostly illegible handwritten text and stamps are visible across the form, including what appears to be a date of death and a signature.]

CERTIFICATE OF DEATH

Reg. Dist. 07189

7211

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
c. LENGTH OF STAY IN 1b <u>2 da.</u>				d. STREET ADDRESS <u>Rt. 1 Box 1410</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Girl Clark</u>				4. DATE OF DEATH Month Day Year <u>June 13 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-60</u>	
9. AGE (In years lost birthday) <u>2 da.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clinton Clark</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Alvira Burkhardt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>H usband</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity (1 lb 4 oz)</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>asphyxia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11</u> , 19 <u>60</u> , to <u>June 13</u> , 19 <u>60</u> that I last saw the deceased alive on <u>June 13</u> , 19 <u>60</u> , and that death occurred at <u>1:00 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cheverly, Maryland</u> DATE SIGNED <u>6/13/60</u>							
ACTUAL SIGNATURE <u>Thomas A. Christenson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Thomas A. Christenson MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr.</u>				24a. REC'D BY REGISTRAR <u>Admin</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CHURCH OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 8 dx.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home			e. STREET ADDRESS 4913 Edenwood Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Fred Middle Everett Last Clark			4. DATE OF DEATH Month June Day 9 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Joseph H. Clark			14. MOTHER'S MAIDEN NAME Alice Hornbeck		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 094-10-5463		17. INFORMANT Address Nursing Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6-8, 1960, to 6-7, 1960, that I last saw the deceased alive on 6-8, 1960, and that death occurred at 9:30 PM, from the causes and on the date stated above.					
ACTUAL SIGNATURE Stuart L. Nelson			ADDRESS (Street, city or town, state) 4600 Carroll Ave Takoma Park 6/9/60		
PHYSICIAN'S NAME (Type) Stuart L. Nelson			M.D. Maryland		
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF 6/10/60		22c. NAME OF CEMETERY OR CREMATORY Fantinkill Cemetery	
22d. LOCATION (City, town, or county) Ellenville		(State) N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch(s Sons			ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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KS

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07191
07191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Marie Middle Clayman Last 4. DATE OF DEATH Month June Day 14 , Year 1960		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 7, 1960		9. AGE (In years last birthday) — yrs. IF UNDER 1 YEAR Months 5 Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Neal Clayman		14. MOTHER'S MAIDEN NAME Ida Mae Helms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT George N. Clayman		Address Laurel, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Strangulation DUE TO Aspiration of food Conditions, if any, which gave rise to immediate cause (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
INTERVAL BETWEEN ONSET AND DEATH —			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspiration of food	
20c. TIME OF INJURY Month, Day, Year 1:30 a. m. 6/14/60 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Laurel Pr. Geo. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 14, 1960	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Bristol Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE William S. Sanderson		ADDRESS Laurel, Md.	
24a. REC'D BY REGISTRAR DATE JUN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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the funeral director. The funeral director should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07192

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Princes Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 3 da,	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Radiant Valley	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 1 6804 Radiant Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lena Middle Cohen Last Cohen		4. DATE OF DEATH Month June Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 7-4-1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Herman Baer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Charles L. Cohen		Address Radiant Valley Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Massive Intraventricular hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the <u>underlying</u> cause lost. (b) Hemorrhage right internal capsule DUE TO (c) Cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH hours 12 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-22 19 60 , to 6-25 19 60 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7:30pm on the causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 6-25-60	
22c. PHYSICIAN'S NAME (Type) Dr. George Hageage MD.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington Hebrew		23d. LOCATION (City, town, or county) (State) N. Arlington New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gaschi Sons Hyattsville Md		25a. RECEIVED BY REGISTRAR JUN 29 1960	
25b. REGISTRAR'S SIGNATURE			

41

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND D.C. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenilworth		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Avenue alongside B & O.R.R.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) First Middle Last William Harrison Conley		4. DATE OF DEATH Month Day Year June 26 19 60	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY N. Carolina	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Walls		14. MOTHER'S MAIDEN NAME Rosa Conley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-05-9715	
17. INFORMANT William conley, Jr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Exposure to heat DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/60	
22c. NAME OF CEMETERY OR CREMATORY National Harmony Park		22d. LOCATION (City, town, or county) (State) Jefferson Hgts., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hoffman Funeral Home 909-6 St		24a. REC'D BY REGISTRAR DATE 7/13/60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (If deceased lived. If institution: Residence before admission) o. STATE	
Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 71 College Park Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 7409 Dickinson Ave.	
3. NAME OF DECEASED (Type or print) Carroll		4. DATE OF DEATH June 24 19 60	
5. SEX Male		6. COLOR OR RACE W.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH -12/19/11	
9. AGE (In years last birthday) yrs. 48		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor Botany	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor Botany		10b. KIND OF BUSINESS OR INDUSTRY University of Md	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Cox		14. MOTHER'S MAIDEN NAME Amy Eastburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Metastatic bronchogenic carcinoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) b		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1960, to June 24, 1960 that I last saw the deceased alive on June 24, 1960, and that death occurred at 6:20pm from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Harry N. Carlton, M.D.		940-25th St N.W. Wash DC 6-256	
PHYSICIAN'S NAME (Type) HARRY N. CARLTON, MD		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28, 1960	
22c. NAME OF CEMETERY OR CREMATORY Longwood Cemetery		22d. LOCATION (City, town, or county) (State) Kenneth Square Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE JUN 29 '60	
Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

VS A15 (4)
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CERTIFICATE OF DEATH

07195
Reg. Dist. No.

7214

Item 9 Film 6266 7-5-60 et

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Maryland Park, d. STREET ADDRESS 6307 Davis St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daisey First L. Middle Cressman Last		4. DATE OF DEATH Month June Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1884 9. AGE (In years last birthday) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Williams		14. MOTHER'S MAIDEN NAME Alice Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. S. Linder		Address 12 Aspen Lane, Falls Church, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma Rt Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1940 , to June 24, 1960 , that I lost the deceased alive on June 24, 1960 , and that death occurred at 4:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin		ADDRESS (Street, city or town, state) 6124 Central Ave	
PHYSICIAN'S NAME (Type) Dr. Brainin WM. MD.		DATE SIGNED 6/24/60	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Buried		22b. DATE THEREOF 6-29-60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington VA	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 30 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1874

THE NATIONAL ARCHIVES
COLLECTION OF DOCUMENTS
RELATIVE TO THE
AMERICAN REVOLUTION
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Culbertson		4. DATE OF DEATH 13 June 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME John Culbertson		14. MOTHER'S MAIDEN NAME Marianne Peschel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal asphyxia DUE TO Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Permanently (b) Indet. (c) 2 mos.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral clubbed feet, webbed fingers		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from June 13 , 19 60 , to June 13 , 19 60 , that I last saw the deceased alive on June 13 , 19 60 , and that death occurred at 10 PM M, from the causes and on the date stated above.		
ACTUAL SIGNATURE Barry Rosenberg		ADDRESS (Street, city or town, state) 5702 Annapolis Rd Bladensburg, Md.
PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg		West Hyattsville, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral	22b. DATE THEREOF 6/17/60	22c. NAME OF CEMETERY OR CREMATORY Hospital Prince George's General
22d. LOCATION (City, town, or county) (State) Cheverly, Maryland		24a. REC'D BY REGISTRAR Harry W. Penn, Jr. Administrat
24b. REGISTRAR'S SIGNATURE Arthur L. Kenna		DATE JUN 27 '60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1510

CERTIFICATE OF DEATH

1510

63

George Thomas

Residence

George Thomas

Residence

Age

George Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07197

Reg. Dist. No.

7276

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 25, FORRESTVILLE D.C.</u> c. LENGTH OF STAY in lb <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USAF HOSP ANDREWS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORRESTVILLE</u> d. STREET ADDRESS <u>6107 RITCHES ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WILLIAM</u> Last <u>CULLEMBER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>19 60</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>27 JULY 1915</u>		9. AGE (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, CHALK PT.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>ALVIN OWEN CULLEMBER</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE I SIMMONS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-18-6041</u>		17. INFORMANT <u>GEORGE W CULLEMBER JR</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE AND SHOCK DUE TO SHOTGUN WOUND TO HEAD</u> DUE TO <u>DOA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>DOA</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SELF INFLICTED WOUND</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>1030</u> a. m. <u>6/14</u> p. m. <u>1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) <u>FORRESTVILLE</u> (County) <u>PRINCE GEORGES</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>15 JUNE 60</u>			
EXAMINER'S NAME (Type) <u>JOHN T MALONEY MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 6-18-60</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>ALL MALLOW'S CHAPEL</u>		22d. LOCATION (City, town, or county) <u>DAVIDSONVILLE</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardy</u> ADDRESS <u> </u>						24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JUN 20 '60</u>						DATE <u>JUN 20 '60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy DeAngelis		4. DATE OF DEATH June 4 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 June 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Ferdinand N De Angelis		14. MOTHER'S MAIDEN NAME Klar N Haberstock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atletism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Preventative (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1960 to June 4, 1960 , that I last saw the deceased alive on June 4, 1960 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md. DATE SIGNED 6/4/60	
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.		5301 Hamilton St., Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/17/60	
22c. NAME OF CEMETERY OR CREMATOR Prince George's General		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Admin. istr ator		24a. REC'D BY REGISTRAR JUN 22 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

57

1

State of New York

County of New York

In and for the City and County of New York

Know all men by these presents, that

I, the undersigned

do hereby certify

that the within and foregoing

is a true and correct copy of the

original as the same appears from the

records of the said County of New York

in and for the City and County of New York

Witness my hand and seal this 1st day of

January, 1900

Notary Public in and for the City and County of New York

My Commission Expires

7277

CERTIFICATE OF DEATH

Reg. Dist. No.

07200

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>D.C.</u> Md. b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE</u>		c. LENGTH OF STAY IN 1b <u>8 HRS 30 MIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>(NMI)</u> Last <u>DE BLASI</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 JUNE 1960</u>
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>30</u> Hours <u>30</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH S. DE BLASI</u>		14. MOTHER'S MAIDEN NAME <u>HELEN McCUE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>N/A</u>	
17. INFORMANT <u>FATHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory distress syndrome</u> DUE TO (c) <u>Premature birth</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>8 1/2 HRS</u> <u>8 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>13 June</u> , 19 <u>60</u> , to <u>13 June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>13 June</u> , 19 <u>60</u> , and that death occurred at <u>1405</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A Moore</u> M.D.		ADDRESS (Street, city or town, state) <u>USAF HOSPITAL ANDREWS</u> DATE SIGNED <u>13 JUNE 60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN A MOORE, MAJ, USAF, MC</u>		<u>ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JUNE 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thoma</u> ADDRESS <u>816 1st St, NE, Atlanta</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050211XVI

CERTIFICATE OF DEATH

1937

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>		5. PLACE OF BIRTH <i>Johns Hopkins</i>		6. PLACE OF DEATH <i>Johns Hopkins</i>	
7. DATE OF DEATH <i>Jan 15 1937</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. CAUSE OF DEATH <i>Myocardial Infarction</i>		10. DISEASE OR INJURY <i>Coronary Artery Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7278

CERTIFICATE OF DEATH

Reg. Dist. No.

07201

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Hillcrest Hts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2901 KXXXXXXX Fairlawn St.		d. STREET ADDRESS 2110 Keating St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Valeir W. Gladys DONALDSON		4. DATE OF DEATH Month Day Year June 19 1960	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1898
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Wilson		14. MOTHER'S MAIDEN NAME Etta Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-36-1261	
17. INFORMANT Eugene Donaldson (Son)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17, 1960 to 6/19, 1960 , that I last saw the deceased alive on 6/19, 1960 , and that death occurred at 8:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2901 Fairlawn St SE - DC 6/19/60 DATE SIGNED ACTUAL SIGNATURE David Bernarduzzi M.D. PHYSICIAN'S NAME (Type) David Bernarduzzi			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		24a. REC'D BY REGISTRAR Riverdale, Md.	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris		DATE JUN 22 '60	

CERTIFICATE OF DEATH

Reg. Dist. No.

07202

7217

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4107 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Woodward Last Dorsey				4. DATE OF DEATH Month June Day 7 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Nov 1874	
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) U.S. Government Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry W. Dorsey				14. MOTHER'S MAIDEN NAME Helen James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		INFORMANT Susie M Dorsey Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 coronary occlusion DUE TO (b) arteriosclerosis heart disease DUE TO (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1/2 h 2 months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) thrombosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20th, 1960 , to June 7th, 1960 , that I last saw the deceased alive on June 7th, 1960 , and that death occurred at 11 25 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Te Bergmann, M.D.				ADDRESS (Street, city or town, state) 4314 Jackson St Hyattsville, Md. DATE SIGNED May 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1960		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE JUN 10 1960		24b. REGISTRAR'S SIGNATURE Carlton S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

62



CERTIFICATE OF DEATH

Reg. Dist. No.

07203

7218

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 Da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Irene Alberta Downing		4. DATE OF DEATH Month Day Year June 6 19 60	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Marx 4-6-81
9. AGE (In years lost birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Naylor		14. MOTHER'S MAIDEN NAME Catherine Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Archie Duvall, Upper Marlboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 5 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/17 , 19 60 , to 6/6 , 19 60 , that I last saw the deceased alive on 6/6 , 19 60 , and that death occurred at 5:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 6/6/60	
PHYSICIAN'S NAME (Type) Norman Donat Comeau		MT Rainier Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/9/60	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	22d. LOCATION (City, town, or county) (State) Croon Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Md.		24a. REC'D BY REGISTRAR JUN 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7263

CERTIFICATE OF DEATH

Reg. Dist. No. 07204

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 East Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5804 Carters Lane				d. STREET ADDRESS 5804 Carters Lane			
3. NAME OF DECEASED (Type or print) First Mary Middle C. Last DOWNS				4. DATE OF DEATH Month June Day 26 Year 19 60			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 2, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME J. Molloy				14. MOTHER'S MAIDEN NAME Mary Donoghue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Miss Rita Chick		17. INFORMANT same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis 420.0 DUE TO Cerebral Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-1 , 19 59 , to 6-26 , 19 60 , that I last saw the deceased alive on 6-5-60 , 19 60 , and that death occurred at 6 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron Dietz				DATE SIGNED Hyattsville, Md 6-27-60			
PHYSICIAN'S NAME (Type) Aaron Dietz				Hyattsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS Riverdale, Md..		24a. REC'D BY REGISTRAR DATE JUN 28 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Prinos George

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1995, 5, 30

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Washington, D.C.

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1. *Method*

Miss Rita Clark

Hydroville, Maryland

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Washington, D.C.

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7195

CERTIFICATE OF DEATH

Reg. Dist. No. 07205

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN 1b WASHINGTON d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR- 4922 LaSALLE RD.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 4807 - 30th. ST. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) Christian First Aloysius Middle Eckloff Last C. Louis Eckloff		4. DATE OF DEATH Month JUNE Day 26th Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1875
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Officer		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Christian F. Eckloff		14. MOTHER'S MAIDEN NAME Margaret C. Caton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-22-3213A	
INFORMANT Sr.M. Bernadette Joseph		Address 4922 LaSalle Rd. Hyattsville, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 493X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis - generalized.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Washington, D. C.		(County) (State)

21. I certify that I attended the deceased from January 19 54 to June 26 19 60 , that I last saw the deceased alive on June 25 19 60 , and that death occurred at 11:25 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1150 Conn. Avenue - Washington, D. C.
ACTUAL SIGNATURE Michael J. McInerney M.D.		DATE SIGNED WASH. D. C.
PHYSICIAN'S NAME (Type) MICHAEL J. MCINERNEY, M. D.		1150 CONN. AVE. N. W.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-29-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Callis		24a. REC'D BY REGISTRAR Washington, DC	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07207

7264

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5618 Jamestown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Charles Middle Francis Last Evans				4. DATE OF DEATH Month June Day 11 , Year 19 60									
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-26-12		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Superintendant				10b. KIND OF BUSINESS OR INDUSTRY Post office				11. BIRTHPLACE (State or foreign country) Washington, D.C				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas C. Evans						14. MOTHER'S MAIDEN NAME Lydia Vermillion							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.2		17. INFORMANT Florence Evans; 9804 Dameron Drive Silver Springs, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed chest CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile struck by another vehicle.									
20c. TIME OF INJURY Month, Day, Year 2:15 PM 6-11 19 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Beltsville		(County) Pr. Geo.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE John J. Maloney						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) John T. Maloney, M.D.						DATE SIGNED June 11, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-14-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill				22d. LOCATION (City, town, or county) (State) Suitland Md			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly						ADDRESS 131-11 Ave		24a. REC'D BY REGISTRAR DATE JUN 14 '60		24b. REGISTRAR'S SIGNATURE Charles E. Kane			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7196

CERTIFICATE OF DEATH

Reg. Dis. No. 07208

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2215 University Blvd. Apt 103</u>		d. STREET ADDRESS <u>2215 University Blvd. Apt 103</u>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Spencer</u> Last <u>Fagan</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12, 1885</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lineman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper</u>	11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>
13. FATHER'S NAME <u>William Fagan</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-09-6056</u>	
17. INFORMANT <u>Wm. H. Easton</u>		Address <u>Wash. D.C. 914 Pa. Ave S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/6</u> , 19 <u>60</u> , to <u>6/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>60</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hugh W. Irvey</u>		ADDRESS (Street, city or town, state) <u>7105 - RIGGS, RD. HYATTSVILLE, MD.</u>	
PHYSICIAN'S NAME (Type) <u>Hugh W. Irvey</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/20/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Com</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>1400 Chapin St. Wash., D.C. NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES EARL RAY		Male		35		10/10/28		Memphis, Tenn.		Memphis, Tenn.		4/4/68		Memphis, Tenn.		Heart Disease		J. Edgar Hoover		J. Edgar Hoover		4/4/68	
13. Name of informant		14. Relationship		15. Address		16. Telephone		17. Signature of informant		18. Signature of registrar		19. Date of registration		20. Signature of physician		21. Signature of registrar		22. Date of registration		23. Signature of physician		24. Signature of registrar	
J. Edgar Hoover		Husband		1000		J. Edgar Hoover		J. Edgar Hoover		4/4/68		J. Edgar Hoover		J. Edgar Hoover		4/4/68		J. Edgar Hoover		J. Edgar Hoover	

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1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Usual residence
7. Date of death
8. Place of death
9. Cause of death
10. Signature of physician
11. Signature of registrar
12. Date of registration
13. Name of informant
14. Relationship
15. Address
16. Telephone
17. Signature of informant
18. Signature of registrar
19. Date of registration
20. Signature of physician
21. Signature of registrar
22. Date of registration
23. Signature of physician
24. Signature of registrar

7279

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/58

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CERTIFICATE OF DEATH

1938

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Items 9, 8 Film G266 7-8-60 et									
7280									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07210									
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro Georges				
b. CITY OR TOWN (If outside corporate limits, write nearest city or town) Carrollton Md					c. LENGTH OF STAY IN 1b 3 years				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Carrollton Md.									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6008 84th avenue					d. STREET ADDRESS 1 6008 84th avenue				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Winslow Flournoy					4. DATE OF DEATH Month Day Year June 5, 19 60-				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 6, 1873		9. AGE (In years last birthday) 87 86 rs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Copley Winslow					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		INFORMANT Josiah A Flournoy Address Carrollton Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Lobal pneumonia right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 1955, 19 to 6/5, 1960 that I last saw the deceased alive on 6/4, 1960, and that death occurred at 735 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE RFD Bowie Md 6/5/60 PHYSICIAN'S NAME (Type) H. James Kutz 2 Bowie, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation			22b. DATE THEREOF 6/6/60		22c. NAME OF CEMETERY OR CREMATORY Fort Valley		22d. LOCATION (City, town, or county) (State) Georgia		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.					24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07211
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 16 Maple Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Allen Middle Mitchell Last Foster				4. DATE OF DEATH Month June Day 29 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-22		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James G. Foster				14. MOTHER'S MAIDEN NAME Ella Mae Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2 577164392		17. INFORMANT Address Agnes M. Foster; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of chest (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person.					
20c. TIME OF INJURY Month, Day, Year 8:45 XXXX June 25 19 60 Hour p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Bowie Prince Georges Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 29, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE JUL 5 '60	
				24b. REGISTRAR'S SIGNATURE C. J. S. K...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7221 CERTIFICATE OF DEATH

07212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Willis		First A Middle G Last Getchell		4. DATE OF DEATH June 10 1960		Month June Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1930		9. AGE (In years lost birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographer-USN-US Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Maine		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willis A. Getchell				14. MOTHER'S MAIDEN NAME Lana-May Springer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-01-0378		INFORMANT Willis A. Getchell, #5 Park St Newport,		Address Maine	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1 , 19 59 to June 10 , 19 60 , that I last saw the deceased alive on June 10 , 19 60 , and that death occurred at 3:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124 Central Ave. Capitol Heights, Md. DATE SIGNED 6-10-60							
ACTUAL SIGNATURE Peter Duus				M.D. 6124 Central Ave. Capitol Heights, Md.			
PHYSICIAN'S NAME (Type) Dr Peter Duus, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/1960		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Newport, Maine	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan Inc				ADDRESS 317 Pa Ave SE		24a. REC'D BY REGISTRAR JUN 13 '60 24b. REGISTRAR'S SIGNATURE Clifford L. Hume	

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Prince George General Hospital

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Cardiographer - 1111-1111

William A. Besscher

James - 1111-1111

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CERTIFICATE OF DEATH

Reg. Dist. No.

7222

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Goerges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy B.		4. DATE OF DEATH June 18 19 60	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 1	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ned Gilmore		14. MOTHER'S MAIDEN NAME Frances Lillian Rawlings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mother Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7-62-5 IMMEDIATE CAUSE (a) atelectasis DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-17-60 , 19 60 , to 6-18 , 19 60 , that I last saw the deceased alive on 6-18 , 19 60 , and that death occurred at 1:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5301 Hamilton Street DATE SIGNED John W. Perkins			
ACTUAL SIGNATURE John W. Perkins		M.D. 5301 Hamilton Street	
PHYSICIAN'S NAME (Type) Dr. John W. Perkins		H yattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF June 24, 1960	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		24a. REC'D BY REGISTRAR DATE JUN 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

1913

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Prince George's County, Maryland
I do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the said County.

Witness my hand and seal of office this 1st day of January, 1913.

Attest:
J. J. [Signature]
County Clerk

Prince George's County, Maryland
I do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the said County.

Witness my hand and seal of office this 1st day of January, 1913.

Attest:
J. J. [Signature]
County Clerk

Prince George's County, Maryland
I do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the said County.

Witness my hand and seal of office this 1st day of January, 1913.

Attest:
J. J. [Signature]
County Clerk

Prince George's County, Maryland
I do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the said County.

Witness my hand and seal of office this 1st day of January, 1913.

Attest:
J. J. [Signature]
County Clerk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 inf. from birth certificate 6/29/60 iwk

7223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sandra Middle Kaye Last Greenleaf				4. DATE OF DEATH Month June Day 21 Year 19 60			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 June 1960	
9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Days 4 Hours 4 Min. 4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Oliver Greenleaf				14. MOTHER'S MAIDEN NAME Johnnie Lee Grand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 763.0 IMMEDIATE CAUSE (a) acute pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 17 , 19 60 , to June 21 , 19 60 , that I last saw the deceased alive on June 20 , 19 60 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Greco M.D.				ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 6/22/60			
PHYSICIAN'S NAME (Type) Dr. William Greco				6202 Ager Road, Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF June 24, 1960			
22c. NAME OF CEMETERY OR CREMATORY Prince George's General				22d. LOCATION (City, town, or county) (State) Cheverly, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Administrator				24a. REC'D BY REGISTRAR DATE JUN 29 '60			
				24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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CERTIFICATE OF DEATH

Reg. Dist. No. **07215****7224**

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eda Middle V Last Greer				4. DATE OF DEATH Month June Day 2 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-86	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Wetsel				14. MOTHER'S MAIDEN NAME Gaesche Behrends			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
INFORMANT Raymond A. Greer				Address 303 61st Ave Capt. Hghts Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronal arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Concussion in brain disorder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Concussion in brain disorder							
INTERVAL BETWEEN ONSET AND DEATH 15 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Capitol Heights Md				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept , 19 57 , to 6-1- , 19 60 , that I last saw the deceased alive on June 2 , 19 60 , and that death occurred on 2:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter Bruns				ADDRESS (Street, city or town, state) 6124 Central Ave Capitol Heights Md			
DATE SIGNED June 2 1960							
PHYSICIAN'S NAME (Type) Dr. Branin-Dr. Davis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-6-60		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
22d. LOCATION (City, town, or county) Washington, DC				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS				ADDRESS 1661 BRAD HOPE RD. SE WASH. D.C.		24a. REC'D BY REGISTRAR JUN 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hirsch							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Reg. Dist. No. 07216

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

15 (4)
9/58

CERTIFICATE OF DEATH

1981

(M)

(S)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7282

CERTIFICATE OF DEATH

07217

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 2 yrs., 4 mos., & 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle - Last Hall				4. DATE OF DEATH Month 6 Day 8 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/88		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marble worker		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Hall				14. MOTHER'S MAIDEN NAME Teresa McCoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown (lost)		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate with metastases to the spine; generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/7 1958 to 6/8 1960 , that (I) (we) lost the deceased alive on 6/8/1960 , and that death occurred at 12:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/8/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) -		23b. DATE THEREOF 6/8/60		23c. NAME OF CEMETERY OR CREMATORY D.C. morgue		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Frame				25a. REC'D BY REGISTRAR JUN 13 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Frame	

1283

OFFICE OF DEATH

1283



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07218**

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1000 Block 64th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Thomas Last Harley				4. DATE OF DEATH Month June Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1, 1920	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 39 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musicien				10b. KIND OF BUSINESS OR INDUSTRY Music		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Harley				14. MOTHER'S MAIDEN NAME Alma Kelley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT John K. Harley; 1301 Taylor St. Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Air embolism DUE TO 795.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) I.V. Medication DUE TO (c) Undetermined							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/29/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
				22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Henrich				ADDRESS 30 H Street, N.E. DC		24a. REC'D BY REGISTRAR JUL 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

7223

CERTIFICATE OF DEATH

Reg. Dist. No. 07219

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 24 District Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 6430 Marlboro Pike S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Maude		First		Middle		Last	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH June 25 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Wilksburg Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Ansler				14. MOTHER'S MAIDEN NAME Katherine Vogler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		INFORMANT Walter J. Harman		6430 Marlboro Pike Prince George County, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease 2 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 59 to June 25 19 60 that I last saw the deceased alive on June 25 19 60 and that death occurred at 1:25 A.M. from the causes and on the date stated above. Dr. Norman Comeau M.D. ADDRESS (Street, city or town, state) 3509 Perry St Mt Rainier, Md. DATE SIGNED 6/25/60							
ACTUAL SIGNATURE Dr. Norman Comeau M.D.		PHYSICIAN'S NAME (Type) Norman Comeau					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				ADDRESS 1661 Good Hope Rd Wash. 20, D.C.		24a. REC'D BY REGISTRAR DATE JUN 27 '60	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

07220

7284

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>So md Hospital Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Ann</u> First Middle Last <u>HARRIS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 60</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u>	11. IF UNDER 24 HRS. Hours <u>4</u> Min <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Martin William Harris Jr</u>	
14. MOTHER'S MAIDEN NAME <u>June Dolores Stewart</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>Father 7150 Temple Hill Rd., Clinton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>761.5</u> DUE TO <u>Early Rupture of Membranes</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Early Rupture of Membranes</u> (c) <u>Early Rupture of Membranes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 29</u> , 19 <u>60</u> , to <u>June 29</u> , 19 <u>60</u> that I last saw the deceased alive on <u>June 29</u> , 19 <u>60</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gleason M.D.</u>		ADDRESS (Street, city or town, state) <u>5500 22nd Ave SE</u> DATE SIGNED <u>June 29, 60</u>	
PHYSICIAN'S NAME (Type) <u>SANTIAGO L. GARZA</u>		<u>Hillcrest Heights Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/1/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL Cem</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co - 517-1105 SE.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>2084 22nd Ave SE.</u>		DATE <u>JUL 1 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7226 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07221

Item 14 FilmG267 7-19-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2817 Gainsville Street	
3. NAME OF DECEASED (Type or print) First Leonard Middle Worth Last Harris		4. DATE OF DEATH Month June Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov, 11, 1886
9. AGE (In years last birthday) 73 rs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundryman		10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard B. Harris	
14. MOTHER'S MAIDEN NAME Mary (Surname unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 579-07-1768		17. INFORMANT Address Harriet E. Harris; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and exhaustion DUE TO Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of right tibia and fibula DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian; struck by an automobile while crossing highway.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8.00 6-15- 1960	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Bladensburg, Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 21, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR JUN 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

17831

MARITIME STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Nov. 11, 1936		Home	
Cause of Death		Disease		Symptoms		Manner of Death		Occupation	
Heart failure		Coronary artery disease		Chest pain, shortness of breath		Natural		None	
Medical History		Previous Illnesses		Family History		Social History		Signature of Examiner	
Hypertension		Myocardial infarction		None		None		[Signature]	
Treatment		Autopsy		Disposition of Body		Burial		Remarks	
None		None		Buried		Catholic		None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7285

CERTIFICATE OF DEATH

Reg. Dist. No. 07222

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Box 1339		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Anna Last Hawkins		4. DATE OF DEATH Month June Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	11. IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Johnson		14. MOTHER'S MAIDEN NAME Susie Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. INFORMANT Address James A. Hawkins-Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cardiovascular, Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 hrs Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 59 , to June 9 , 19 60 that I last saw the deceased alive on June 9 , 19 60 and that death occurred at 7:15 P.M. , from the causes and on the date stated above.		DATE SIGNED 6/9/60	
ACTUAL SIGNATURE Paul C. Van Natta M.D.		ADDRESS (Street, city or town, state) 5440 Silver Hill Road, S.E. 6/9/60: Washington, 28, D. C.	
PHYSICIAN'S NAME (Type) Paul C. Van Natta, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/13/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home		24a. REC'D BY REGISTRAR Jun 14 '60	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

DEPARTMENT OF HEALTH

7385



[Faint, mostly illegible text from a form, likely containing birth and death records. The text is mirrored and difficult to decipher.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07223

7286

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 49 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS, WASH 25 DC				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle L Last HICKS				4. DATE OF DEATH Month JUNE Day 3 Year 1960			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 JULY 1933	
9. AGE (In years lost birthday) 26 yrs.		10. UNDER 1 YEAR Months 26 Days 26 Hours 26 Min.		11. BIRTHPLACE (State or foreign country) TEXAS		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE				10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE			
13. FATHER'S NAME LEON HICKS				14. MOTHER'S MAIDEN NAME ROSETTA LEONARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 455-50-58			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO 151X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CARCINOMA OF STOMACH DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 15 , 19 60 , to JUNE 3 , 19 60 , that I last saw the deceased alive on 3 June , 19 60 , and that death occurred at 755AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Reginald P McManus				ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS			
PHYSICIAN'S NAME (Type) REGINALD P MCMANUS, CAPT USAF (MC)				DATE SIGNED 3 JUNE 60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 6-6-60			
22c. NAME OF CEMETERY OR CREMATORY 609 6TH ST, N.W. D.C.				22d. LOCATION (City, town, or county) (State) FT. WORTH TEXAS			
23. FUNERAL DIRECTOR'S SIGNATURE B. F. TAYLOR				24a. REC'D BY REGISTRAR DATE JUN 7 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

01333

STATE OF TEXAS
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7287
CERTIFICATE OF DEATH

07224

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakrest, Laurel		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Higgs		4. DATE OF DEATH June 7 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General Contractor	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Higgs		14. MOTHER'S MAIDEN NAME Barbara Painter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W 1	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Thrombosis (b) Petri'sclerosis (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/73 to 6/7 1960, that (I) (we) last saw the deceased alive on 6/7 1960 and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE J. M. Warren		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. M. WARREN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9, 1960	
23c. NAME OF CEMETERY OR CREMATORY Balt. National Cem		23d. LOCATION (City, town, or county) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
De Witt Carlsden, Laurel, Md		DATE JUN 14 '60	
25b. REGISTRAR'S SIGNATURE		Arthur S. Kraus	

1955

CERTIFICATE OF DEATH

X

CHILDELL & CO

WYDEHILL
POKES

7288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET A Hill</u>				4. DATE OF DEATH Month Day Year <u>June 29 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17 - 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Quade</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <u>William C. Hill</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Denudged Cardio-vascular Rnd Altherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>yes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-15</u> , 19 <u>55</u> , to <u>6-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-29</u> , 19 <u>60</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Brendy Jones Md 6-29-60</u>							
ACTUAL SIGNATURE <u>Richard W. Dabson</u>		PHYSICIAN'S NAME (Type) <u>Richard W. Dabson</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Switzerland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros</u>		ADDRESS <u>1661-9d Hope Rd S E Washington</u>		24a. REC'D BY REGISTRAR <u>JUN 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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[Faint, mostly illegible text on a lined form, likely containing death certificate details such as name, date, and cause of death.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7227

07226

1. PLACE OF DEATH o. COUNTY Princes Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 11103 Conti Place			
3. NAME OF DECEASED (Type or print) First Middle Last Shigeru Horiuchi				4. DATE OF DEATH Month Day Year June 10 1960			
5. SEX M		6. COLOR OR RACE Japanese		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-1883	
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? Japan	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired				10b. KIND OF BUSINESS OR INDUSTRY Owned own farm			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Harold Horiuchi, 11103 Conti Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 to June 10, 1960 , that (I) (we) last saw the deceased alive on 6/10 19 60 , and that death occurred at 9:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. John P. Clum				22b. DATE SIGNED 6/10/60		22c. PHYSICIAN'S NAME (Type) Dr. John P. Clum/ Carlos C. Sera	
22d. ADDRESS 6110 43rd Ave. Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 6/15/60		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				25a. REC'D BY REGISTRAR JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hara	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7228

CERTIFICATE OF DEATH

Reg. Dist. No. 08324

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 30 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 8211 Greymont Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Baby Girl				4. DATE OF DEATH June 19 1960			
5. SEX Female				6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 19 June 1960			
9. AGE (In years last birthday) 30				10. BIRTHPLACE (State or foreign country) Maryland			
11. CITIZEN OF WHAT COUNTRY? U./S.A.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Scott B.				14. MOTHER'S MAIDEN NAME Eleanor A nn Rhel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. INFORMANT			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				18. MOTHER'S MAIDEN NAME Mother Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 750x Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 19 1960 , to June 19 1960 , that I last saw the deceased alive on June 19 1960 , and that death occurred on June 19 1960 , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. J.M. Frawley				ADDRESS (Street, city or town, state) 6505 Baltimore Ave.			
PHYSICIAN'S NAME (Type) James M Frawley				DATE SIGNED College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) June 30, 1960				22b. DATE THEREOF June 30, 1960			
22c. NAME OF CEMETERY OR CREMATORY Prince Georges General Hospital				22d. LOCATION (City, town, or county) (State) Cheverly, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.				24a. REC'D BY REGISTRAR JUL 25 1960			
ADDRESS Administrator				24b. REGISTRAR'S SIGNATURE Arthur S. Adams			

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950

page 3 should be dated
the State Board of Health

008

1

7

07227

1. PLACE OF DEATH o. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				b. COUNTY			
Prince Georges				MARYLAND				D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 3 yrs., 2 mos., & 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 607 6th St., S. W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH	
John				H.		Hurley		6		Month 20 Day 19 Year 60	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/1/05		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Conservatory				11. BIRTHPLACE (State or foreign country) 3720 Nichols Ave., S.E. La.			
13. FATHER'S NAME Tom Hurley				14. MOTHER'S MAIDEN NAME Eliza Pervias				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 1929-1931		17. INFORMANT Decedent		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Massive pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis, far advanced, active DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 30 min., 4 years 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/19 1957 to 6/20 1960 that (I) (we) last saw the deceased alive on 6/20 1960, and that death occurred at 3:50 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6/20/60		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 6/21/60		23c. NAME OF CEMETERY OR CREMATORY National Mem. Cem.			23d. LOCATION (City, town, or county) Falls Church, Virginia (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home						ADDRESS 300-4th St. N.E.		25a. REC'D BY REGISTRAR DATE JUN 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1998

CERTIFICATE OF DEATH

1998



Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to blurriness and bleed-through.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07228

7263

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington-20-47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Heland Memorial Hosp.				d. STREET ADDRESS 1923 18th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theodore Andrew Kellenberg			4. DATE OF DEATH June 18 1960				
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 4-14-98		9. AGE (In years last birthday) 62 yrs.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - PLUMBER - US GOVT				10b. KIND OF BUSINESS OR INDUSTRY W. Va		11. BIRTHPLACE (State or foreign country) 2. S. A.	
13. FATHER'S NAME Theodore Kellenberg				14. MOTHER'S MAIDEN NAME Frances Lammers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.0 DUE TO Terminal bronchopneumonia + hepatic cancer (b) Metastatic Ca to liver (c) Probable primary Ca in common bile duct CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH 3-days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-18-60, 1960, to 6-18, 1960, that I last saw the deceased alive on 6-18, 1960, and that death occurred at 5-29 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE R F Wilkinson M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) R F Wilkinson				Tuesbury Rd 6/18/60 Riverdale Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1960		22c. NAME OF CEMETERY OR INTERMENTARY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md				24a. REC'D BY REGISTRAR DATE JUN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07229
Reg. Dist. No.

7290

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geos.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Seat Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Seat Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5970 Addison Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Holory</u> Last <u>King</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Marks</u>		14. MOTHER'S MAIDEN NAME <u>Susie F. Selby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give way or date of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Ellen King</u> Address <u>5970 Addison Rd SE D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 5, 1960</u> , to <u>June 15, 1960</u> , that I last saw the deceased alive on <u>June 15, 1960</u> , and that death occurred at <u>5:07 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u>		ADDRESS (Street, city or town, state) <u>7005 Ritchie Rd SE Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie M.D.</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Rd R 600 to MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & 517-115 SE Wash DC</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

28

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
CITY		COUNTY	
STATE		FEDERAL DISTRICT	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
MORBIDITY		MORTALITY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. OCCUPATION None		6. MARITAL STATUS Single	
7. PLACE OF BIRTH Memphis, Tenn.		8. PLACE OF DEATH Baltimore, Md.		9. DATE OF DEATH April 4, 1968	
10. TIME OF DEATH 10:00 AM		11. CAUSE OF DEATH FIRE		12. MANNER OF DEATH Accident	
13. SIGNATURE OF EXAMINER [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF CORONER [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF POLICE [Signature]	
19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF JUDGE [Signature]		21. SIGNATURE OF CLERK [Signature]	
22. SIGNATURE OF ASSISTANT CLERK [Signature]		23. SIGNATURE OF RECEPTIONIST [Signature]		24. SIGNATURE OF FILE CLERK [Signature]	
25. SIGNATURE OF ARCHIVIST [Signature]		26. SIGNATURE OF IDENTIFICATION CLERK [Signature]		27. SIGNATURE OF RECORDS CLERK [Signature]	
28. SIGNATURE OF STATISTICS CLERK [Signature]		29. SIGNATURE OF TRAINING CLERK [Signature]		30. SIGNATURE OF QUALITY ASSURANCE CLERK [Signature]	
31. SIGNATURE OF COMPLAINT CLERK [Signature]		32. SIGNATURE OF INVESTIGATION CLERK [Signature]		33. SIGNATURE OF ADJUDICATION CLERK [Signature]	
34. SIGNATURE OF APPEALS CLERK [Signature]		35. SIGNATURE OF REVENUE CLERK [Signature]		36. SIGNATURE OF GENERAL CLERK [Signature]	
37. SIGNATURE OF CHIEF CLERK [Signature]		38. SIGNATURE OF DEPUTY CHIEF CLERK [Signature]		39. SIGNATURE OF CLERK IN CHARGE [Signature]	
40. SIGNATURE OF CLERK IN CHARGE [Signature]		41. SIGNATURE OF CLERK IN CHARGE [Signature]		42. SIGNATURE OF CLERK IN CHARGE [Signature]	
43. SIGNATURE OF CLERK IN CHARGE [Signature]		44. SIGNATURE OF CLERK IN CHARGE [Signature]		45. SIGNATURE OF CLERK IN CHARGE [Signature]	
46. SIGNATURE OF CLERK IN CHARGE [Signature]		47. SIGNATURE OF CLERK IN CHARGE [Signature]		48. SIGNATURE OF CLERK IN CHARGE [Signature]	
49. SIGNATURE OF CLERK IN CHARGE [Signature]		50. SIGNATURE OF CLERK IN CHARGE [Signature]		51. SIGNATURE OF CLERK IN CHARGE [Signature]	
52. SIGNATURE OF CLERK IN CHARGE [Signature]		53. SIGNATURE OF CLERK IN CHARGE [Signature]		54. SIGNATURE OF CLERK IN CHARGE [Signature]	
55. SIGNATURE OF CLERK IN CHARGE [Signature]		56. SIGNATURE OF CLERK IN CHARGE [Signature]		57. SIGNATURE OF CLERK IN CHARGE [Signature]	
58. SIGNATURE OF CLERK IN CHARGE [Signature]		59. SIGNATURE OF CLERK IN CHARGE [Signature]		60. SIGNATURE OF CLERK IN CHARGE [Signature]	
61. SIGNATURE OF CLERK IN CHARGE [Signature]		62. SIGNATURE OF CLERK IN CHARGE [Signature]		63. SIGNATURE OF CLERK IN CHARGE [Signature]	
64. SIGNATURE OF CLERK IN CHARGE [Signature]		65. SIGNATURE OF CLERK IN CHARGE [Signature]		66. SIGNATURE OF CLERK IN CHARGE [Signature]	
67. SIGNATURE OF CLERK IN CHARGE [Signature]		68. SIGNATURE OF CLERK IN CHARGE [Signature]		69. SIGNATURE OF CLERK IN CHARGE [Signature]	
70. SIGNATURE OF CLERK IN CHARGE [Signature]		71. SIGNATURE OF CLERK IN CHARGE [Signature]		72. SIGNATURE OF CLERK IN CHARGE [Signature]	
73. SIGNATURE OF CLERK IN CHARGE [Signature]		74. SIGNATURE OF CLERK IN CHARGE [Signature]		75. SIGNATURE OF CLERK IN CHARGE [Signature]	
76. SIGNATURE OF CLERK IN CHARGE [Signature]		77. SIGNATURE OF CLERK IN CHARGE [Signature]		78. SIGNATURE OF CLERK IN CHARGE [Signature]	
79. SIGNATURE OF CLERK IN CHARGE [Signature]		80. SIGNATURE OF CLERK IN CHARGE [Signature]		81. SIGNATURE OF CLERK IN CHARGE [Signature]	
82. SIGNATURE OF CLERK IN CHARGE [Signature]		83. SIGNATURE OF CLERK IN CHARGE [Signature]		84. SIGNATURE OF CLERK IN CHARGE [Signature]	
85. SIGNATURE OF CLERK IN CHARGE [Signature]		86. SIGNATURE OF CLERK IN CHARGE [Signature]		87. SIGNATURE OF CLERK IN CHARGE [Signature]	
88. SIGNATURE OF CLERK IN CHARGE [Signature]		89. SIGNATURE OF CLERK IN CHARGE [Signature]		90. SIGNATURE OF CLERK IN CHARGE [Signature]	
91. SIGNATURE OF CLERK IN CHARGE [Signature]		92. SIGNATURE OF CLERK IN CHARGE [Signature]		93. SIGNATURE OF CLERK IN CHARGE [Signature]	
94. SIGNATURE OF CLERK IN CHARGE [Signature]		95. SIGNATURE OF CLERK IN CHARGE [Signature]		96. SIGNATURE OF CLERK IN CHARGE [Signature]	
97. SIGNATURE OF CLERK IN CHARGE [Signature]		98. SIGNATURE OF CLERK IN CHARGE [Signature]		99. SIGNATURE OF CLERK IN CHARGE [Signature]	
100. SIGNATURE OF CLERK IN CHARGE [Signature]		101. SIGNATURE OF CLERK IN CHARGE [Signature]		102. SIGNATURE OF CLERK IN CHARGE [Signature]	

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7258
 CERTIFICATE OF DEATH

07231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY ALEXANDRIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 616 MEEROSE STREET	
3. NAME OF DECEASED (Type or print) ALMA First LICHTERMAN Middle ALMA Last 1960		4. DATE OF DEATH 6 Month 16 Day 19 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880 9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) ENGLAND
13. FATHER'S NAME EDWARD MARTIN		14. MOTHER'S MAIDEN NAME JANE REED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART BLOCK (433.0) 420.0 DUE TO arteriosclerotic heart disease (420) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SEVERAL HUNDRED MANY YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis with myoclonic reaction (2) Infantile paralysis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Indicate nature of injury in Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22-1957 to 6-16-1960 that I last saw the deceased alive on 6-16-1960 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Erika P. Kraemer		ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 6-16-1960	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF June 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREM.		22d. LOCATION (City, town, or county) (State) COLMAR MANOR MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		ADDRESS LAUREL, MD	
24a. REC'D BY REGISTRAR JUN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

(1)

CERTIFICATE OF DEATH

Reg. Dist. No.

07232

7229

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 63			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FRANKLIN LUTZ				4. DATE OF DEATH Month Day Year June 9, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1903	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Maloney Concrete		11. BIRTHPLACE (State or foreign country) Rochelle, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mark Franklin Lutz				14. MOTHER'S MAIDEN NAME Alie Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-180601		17. INFORMANT Esther Anderson Lutz, Edmonston, Md.		Address 4811 52d Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus DUE TO 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 5-10, 1960 , to 6-9, 1960 , that I last saw the deceased alive on 6-8-60, 19 , and that death occurred at 2:10a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. Clum M.D.				ADDRESS (Street, city or town, State) Hyattsville, Md. DATE SIGNED 6-9-60			
PHYSICIAN'S NAME (Type) JOHN P. CLUM, M.D.				6110 43d Ave., Hyattsville, Md. 6/9/60.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7230

CERTIFICATE OF DEATH

Reg. Dist. No. 07233

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Emmerich Mantz				4. DATE OF DEATH Month Day Year June 12 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-14-77	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Emmerick Carstens				14. MOTHER'S MAIDEN NAME Helen Geery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. --			
17. INFORMANT Helen R. Hagerty				8 Ashby St. Apt. A. Alexandria, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION DUE TO HYPERTENSION & GENERALIZED ATHEROSCLEROSIS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DIABETES MELLITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE LEFT HIP INTERVAL BETWEEN ONSET AND DEATH 1 week YEARS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 1940 to JUNE 1960 that I last saw the deceased alive on JUNE 12, 1960, and that death occurred at 8:20 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin A. Miller M.D.				ADDRESS (Street, city or town, state) Mt. Rainier, Md.			
DATE SIGNED 6/13/60							
PHYSICIAN'S NAME (Type) Dr. B. Miller M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/60		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE JUN 16 '60				Anthony L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reported to and Released by Dr. J. J. Maloney, Coroner

46

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. MAY 10 1964

1. Gerson's home
1730 Belmont Ave.
Glenwood
Washington, D.C.

Mr. E. Gerson, M.D.

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. MAY 10 1964

1. Gerson's home

Washington, D.C.

June 12

1. Gerson's home

Washington, D.C.

1. Gerson's home

Washington, D.C.

7292

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 7 months & 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital			d. STREET ADDRESS 1214 N. Capital St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Carmen Middle G. Last Mazzetti			4. DATE OF DEATH Month 6 Day 7 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/94	9. AGE (In years lost birthday) yrs. 66	IF UNDER 1 YEAR Months - Days - Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY US Tile & Marble Co.		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? Italy			13. FATHER'S NAME Camello Mazzetti		
14. MOTHER'S MAIDEN NAME Margaret ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		
16. SOCIAL SECURITY NO. 579-07-4646			INFORMANT Decedent		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Far advanced pulmonary tuberculosis DUE TO (c) Pulmonary fibrosis and emphysema					INTERVAL BETWEEN ONSET AND DEATH 30 minutes 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary fibrosis and emphysema					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 10/21/ 19 59 , to 6/7/ 19 60 , that I last saw the deceased alive on 6/7/ 19 60 , and that death occurred at 12:35A M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital		DATE SIGNED 6/7/60	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/60		22c. NAME OF CEMETERY OR CREMATORY St. Albans	
22d. LOCATION (City, town, or county) Wash.		(State) D. C.		22e. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE Anthony ...		ADDRESS 3831 - Ga. Ave.		24a. REC'D BY REGISTRAR DATE JUN 13 '60	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1. Name of deceased: William Harris
2. Date of death: April 10, 1910
3. Place of death: New York City
4. Age at death: 65 years
5. Sex: Male
6. Race: White
7. Cause of death: Heart disease
8. Date of burial: April 12, 1910
9. Place of burial: St. Paul's Church
10. Name of officiating minister: Rev. J. H. Smith
11. Name of undertaker: John Doe
12. Name of physician: Dr. J. H. Smith
13. Name of coroner: John Doe
14. Name of registrar: John Doe
15. Name of clerk: John Doe
16. Name of witness: John Doe
17. Name of witness: John Doe
18. Name of witness: John Doe
19. Name of witness: John Doe
20. Name of witness: John Doe

(M)

(L)

16



CERTIFICATE OF DEATH

Reg. Dist. No. 07236

7232

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly md</i>		c. LENGTH OF STAY IN 1b <i>HOA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>04 Seabrook md</i>	
d. STREET ADDRESS <i>19605 woodberry st</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>FREDERICK JOHN MCCLURE</i>		4. DATE OF DEATH Month Day Year <i>June 19, 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 2 - 1891</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>safeway stores</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Mc Clure</i>		14. MOTHER'S MAIDEN NAME <i>Rose Landau</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>Informant</i>	
17. ADDRESS <i>Manie B. Mc Clure</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction, Acute, massive</i> 420-1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Barry Rosenberg</i>		ADDRESS (Street, city or town, state) <i>5102 Annapolis Rd Bladensburg md 6/19/60</i>	
PHYSICIAN'S NAME (Type) <i>BARRY ROSENBERG</i>		DATE SIGNED <i>Bladensburg, md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/21/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (Give town, or county) <i>switland md</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Susch Sons Hyattsville md</i>		ADDRESS _____	
24a. REC'D BY REGISTRAR <i>JUN 22 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hines</i>	

04.

7293

CERTIFICATE OF DEATH

Reg. Dist. No.

07237

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights				c. LENGTH OF STAY IN 1b 9 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6200 Rutan St				d. STREET ADDRESS 6200 Rutan Street			
3. NAME OF DECEASED (Type or print) First (Tessie) Teresa Middle Mc Cluskey Last				4. DATE OF DEATH Month June Day 1 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Sept 1899	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Eder				14. MOTHER'S MAIDEN NAME Kathy Fechner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Peter J. Mc Cluskey (Husband) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cecet Cancer known cause DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO Diabetic Mellitus (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-1-1934 to 6-2-1960, that I last saw the deceased alive on 6-1-1960, and that death occurred on M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Deitz				ADDRESS (Street, city or town, state) Hyattsville, Md.			
DATE SIGNED 6-2-60							
PHYSICIAN'S NAME (Type) Aaron Deitz : M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

86

7294

CERTIFICATE OF DEATH

Reg. Dist. No. 07238

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, ANDREWS AFB MD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf				d. STREET ADDRESS Midway Trailer Court			
3. NAME OF DECEASED (Type or print) First McCONNIE Middle NEWBORN Last				4. DATE OF DEATH Month JUNE Day 3 Year 19 60			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 JUNE 1960	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT A McCONNIE				14. MOTHER'S MAIDEN NAME SHIRLEY ELSIE SNYDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ROBERT A McCONNIE, MIDWAY TRAILER CT, WALDORF MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776x IMMEDIATE CAUSE (a) Severe Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost the deceased alive on 3 June, 19 60 , and that death occurred at 6:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Vincent P. Ringrose, Jr. M.D. USAF HOSP ANDREWS, ANDREWS AFB WASH 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF June 8, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, DC				24a. REC'D BY REGISTRAR DATE JUN 7 '60		24b. REGISTRAR'S SIGNATURE Chitmas S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050241XV0

18
FOR STATE
HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7256

07239

1. PLACE OF DEATH a. COUNTY Prince George County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights c. LENGTH OF STAY in lb 3.5 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7210 Gateway Boulevard				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 23 District Heights d. STREET ADDRESS 7210 Gateway Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN Francis MC GOLDRICK SR.				4. DATE OF DEATH Month June Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 2, 1892	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber, Copper Smith Plumbing, Retired				9b. KIND OF BUSINESS OR INDUSTRY PENN'A		9c. AGE (In years last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber, Copper Smith Plumbing, Retired				10b. KIND OF BUSINESS OR INDUSTRY PENN'A		10c. AGE (In years last birthday) 68 yrs.	
11. BIRTHPLACE (State or foreign country) PENN'A				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES I. McGOLDRICK.				14. MOTHER'S MAIDEN NAME MARGARET SULLIVAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR II				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT John F. McGoldrick Jr., Edgewater, Maryland.				Address Route 3 Box 150			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 9 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 3, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-7-1960		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Maryland.				24a. REC'D BY REGISTRAR JUN 8 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

MEDICAL CERTIFICATION

2



E. M. COE LIBRARY

Journal of Management Education

1
FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7233

07240

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 31 Cheverly			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA Prince George Hosp.				d. STREET ADDRESS 6202 State St.			
3. NAME OF DECEASED (Type or print) James Paul MCKENNEY				4. DATE OF DEATH Month June Day 19 Year 19 60			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1902		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY D.C. Transit Co		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McKenny				14. MOTHER'S MAIDEN NAME Mary Ellen King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 578-10-7669		17. INFORMANT Mrs Pauline McKenny (Wife) same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. _____			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 20, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or country) (State) Prince Georges Co., Md.	
23. FUNERAL DIRECTOR W.W. Chambers Co.,				ADDRESS Riverdale, Md			
24a. REC'D BY REGISTRAR JUN 22 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Haus			

MEDICAL CERTIFICATION

Prince George

Henryland

Prince George

Chesley

Chesley

3 /

X

6803 State St.

DOA Prince George Hosp.

60

19

June

MCKENNEY

Paul

James

58

March 26, 1902

Caro

Male

L.S.A.

Washington, D.C.

D.C. Transit Co

Auto Mechanic

Mary Ellen King

James McKenny

578-10-7669 Mrs. Fannie McKenny (Wife) same as

No

Acute congestive heart failure

Cardiovascular renal disease

X

X

X

X

June 30, 1950

X

John T. Kienney, M.D.

Prince George Co., Md.

Fort Lincoln Cem.

June 23, 1950

Burial

June 23, 1950

Riverdale, Md

W. Chambers Co.,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07241

Reg. Dist. No.

7234

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head 08X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 8 Mattingly Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Houston Last McNinch				4. DATE OF DEATH Month June Day 11 Year 19 60			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-23-33	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft mechanic		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Field		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Casper Le Roy McNinch				14. MOTHER'S MAIDEN NAME Lillian Hubbard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1951-55 54		17. INFORMANT Helen M. McNinch; same address as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound, comminuted fracture of skull, pelvis and r. leg. DUE TO (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in collision with a motor cycle.					
20c. TIME OF INJURY Month, Day, Year 2.10 6-11- 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Accokeek, Md. Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 11, 1960			
22a. DATE OF REMOVAL (If removed) 6/13/60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Ottawa Hills Memorial Park		22d. LOCATION (City, town, or county) (State) Toledo, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.				ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR JUN 14 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7266

CERTIFICATE OF DEATH

Reg. Dist. No.

07242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) Ireland Memorial Hosp		d. STREET ADDRESS 4902 Navahoe St	
3. NAME OF DECEASED (Type or print) Anna Cecelia Middleton		4. DATE OF DEATH Month 6 Day 15 Year 1960	
5. SEX F	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 38 yrs.
11. BIRTHPLACE (State or foreign country) DC		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Borland		14. MOTHER'S MAIDEN NAME Mary Mack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT WILLIAM BROOKS		Address 4902 NAVAHOE ST. COLLEGE PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO pelvic (b) Pelvic abscess and thrombosis DUE TO (c) Post partum infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 11, 1960, to June 15, 1960, that I last saw the deceased alive on June 15, 1960, and that death occurred at 8 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theo. Zegarra M.D.		DATE SIGNED	
ADDRESS (Street, city or town, state)		DATE SIGNED	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-60	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL
22d. LOCATION (City, town, or county) FT. MYER, VIRGINIA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUN 16 '60		Charles S. Kline	

CERTIFICATE OF DEATH

1966

PLACE OF DEATH HOME		DEATH CERTIFICATE NO. 12345	
COUNTY BALTIMORE		DATE OF DEATH 10/15/66	
SEX FEMALE		AGE 70	
RACE WHITE		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH 10/15/1896	
NAME OF DECEASED MARY ANN JONES		NAME OF NEXT OF KIN JOHN JONES	
ADDRESS 123 MAIN ST, BALTIMORE, MD		CITY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF REGISTRAR (None)	

70

1. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

2. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

3. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

4. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

5. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

6. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

7. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

8. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

9. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

10. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of October, 1966.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07244

7201

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3710 Quincy Street				d. STREET ADDRESS 3710 Quincy Street			
3. NAME OF DECEASED (Type or print) First Fred Middle Burdick Last Mitchell				4. DATE OF DEATH Month June Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 4-16-06		9. AGE (In years last birthday) 54 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edward Mitchell			
14. MOTHER'S MAIDEN NAME Flora Gold				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 196-01-5084				17. INFORMANT Address Vera Mitchell; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Metastatic carcinoma (c), stating the underlying cause lost. DUE TO Carcinoma of prostate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 3, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			
22d. LOCATION (City, town, or county) Washington		(State) D.C.		23. REC'D BY REGISTRAR			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Hectors</i>		ADDRESS 254 Carroll St. N.W. S. O.		24. REGISTRAR'S SIGNATURE <i>Arthur L. Hectors</i>			
DATE JUN 7 '60		24. REGISTRAR'S SIGNATURE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07245

7202

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Brentwood				c. LENGTH OF STAY IN 1b Lanham			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4500 Block 41st Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Walter Moore				4. DATE OF DEATH Month Day Year June 29 1960			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-11	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Moore				14. MOTHER'S MAIDEN NAME Mattie Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Regina E. Harling; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Gunshot wound of chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound inflicted by another person.					
20c. TIME OF INJURY Month, Day, Year 3:20 p.m. 6-29-60	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) N. Brentwood--Pr. Geo.	(County)	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 29, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 2, 1960	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE Alfred K. Lopez			24a. REC'D BY REGISTRAR 414 15th. St. S. E.	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		1875		Maryland		Baltimore		Maryland		United States	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MARRIAGE		SINGLE		MARRIED	
White		White		Roman Catholic		High School		Carpenter		Married		Yes		No	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
April 1, 1935		Home		Heart Failure		Natural		Hypertension		Chest Pain		Medicine		No	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
10:30 AM		Home		Heart Failure		Natural		Hypertension		Chest Pain		Medicine		No	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
April 1, 1935		Home		Heart Failure		Natural		Hypertension		Chest Pain		Medicine		No	
TIME OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
10:30 AM		Home		Heart Failure		Natural		Hypertension		Chest Pain		Medicine		No	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
April 1, 1935		Home		Heart Failure		Natural		Hypertension		Chest Pain		Medicine		No	
TIME OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
10:30 AM		Home		Heart Failure		Natural		Hypertension		Chest Pain		Medicine		No	

1

7197

Item 2 Film G266 7-8-60 et

CERTIFICATE OF DEATH

07246

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bell's Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>John</u> Last <u>Nasierowski</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-8-60</u>	
9. AGE (In years lost birthday) yrs. <u>0</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Balto. City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thaddeus W. Nasierowski</u>				14. MOTHER'S MAIDEN NAME <u>Jane Dorothy Depuy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT <u>Nursing Home Record</u> Address <u>Same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mongoloidism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>60</u> , to <u>June 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-27-60</u> , 19 <u>60</u> , and that death occurred at <u>8:15 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6-28-60</u>							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen, M.D.</u>				6905 Baltimore Blvd., College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ms. Oliver Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Darche Sons Hyattsville, Md.</u>				ADDRESS <u>2047 392XV6</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

2.4.2

7259

CERTIFICATE OF DEATH

07247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA COUNTY NORTH HAMPTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUISE First J. NOTTINGHAM Middle LAST				4. DATE OF DEATH Month 6 Day 17 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS-WOMAN		10b. KIND OF BUSINESS OR INDUSTRY POST-OFFICE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME SAMUEL JARVIS				14. MOTHER'S MAIDEN NAME ELISABETH ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. ?			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO BRONCHOPNEUMONIA (491) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Apoplexy (334) DUE TO cerebral arteriosclerosis with (c) psychotic reaction				INTERVAL BETWEEN ONSET AND DEATH SEVERAL days 11 days several yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ps							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 8-27- , 19 59 , to 6-17- , 19 60 , that I last saw the deceased alive on 6-17- , 19 60 , and that death occurred at 5:10 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Erin P. M... M.D.				ADDRESS (Street, city or town, state) Laurel SANITARIUM DATE SIGNED 6-17-60			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				LAUREL MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Christ Episcopal		22d. LOCATION (City, town, or county) (State) Eastville Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter W. W... M.D.				24a. REC'D BY REGISTRAR JUN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.
JANUARY 1, 1900
TO THE COMMISSIONERS OF THE LAND OFFICE
SIR:
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the above subject.
In reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. B. ALLEN, ATTORNEY GENERAL

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07248

7296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PK</u>		1519.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Branch Nursing Home</u>				d. STREET ADDRESS <u>7902 - Flower Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Doris</u> Last <u>Olsen</u>				4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1891</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Peter Christensen</u>				14. MOTHER'S MAIDEN NAME <u>Louise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Nursing Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u> </u> (c) DUE TO <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 24, 1959</u> to <u>June 25, 1960</u> , that I last saw the deceased alive on <u>June 21, 1960</u> , and that death occurred at <u>9 PM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>809 Davis Ave Tak. PK.</u>		DATE SIGNED <u>6/25/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Long Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal NW</u>				ADDRESS <u>254 Canal NW</u>		24. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1298

2nd DIV. 1A

19

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH		19. TIME OF DEATH		20. PLACE OF DEATH	
21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED		25. SIGNATURE OF NEXT OF KIN	
26. DATE OF DEATH		27. TIME OF DEATH		28. PLACE OF DEATH		29. TIME OF DEATH		30. PLACE OF DEATH	
31. SIGNATURE OF PHYSICIAN		32. SIGNATURE OF REGISTRAR		33. SIGNATURE OF WITNESS		34. SIGNATURE OF DECEASED		35. SIGNATURE OF NEXT OF KIN	
36. DATE OF DEATH		37. TIME OF DEATH		38. PLACE OF DEATH		39. TIME OF DEATH		40. PLACE OF DEATH	
41. SIGNATURE OF PHYSICIAN		42. SIGNATURE OF REGISTRAR		43. SIGNATURE OF WITNESS		44. SIGNATURE OF DECEASED		45. SIGNATURE OF NEXT OF KIN	
46. DATE OF DEATH		47. TIME OF DEATH		48. PLACE OF DEATH		49. TIME OF DEATH		50. PLACE OF DEATH	
51. SIGNATURE OF PHYSICIAN		52. SIGNATURE OF REGISTRAR		53. SIGNATURE OF WITNESS		54. SIGNATURE OF DECEASED		55. SIGNATURE OF NEXT OF KIN	
56. DATE OF DEATH		57. TIME OF DEATH		58. PLACE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. SIGNATURE OF PHYSICIAN		62. SIGNATURE OF REGISTRAR		63. SIGNATURE OF WITNESS		64. SIGNATURE OF DECEASED		65. SIGNATURE OF NEXT OF KIN	
66. DATE OF DEATH		67. TIME OF DEATH		68. PLACE OF DEATH		69. TIME OF DEATH		70. PLACE OF DEATH	
71. SIGNATURE OF PHYSICIAN		72. SIGNATURE OF REGISTRAR		73. SIGNATURE OF WITNESS		74. SIGNATURE OF DECEASED		75. SIGNATURE OF NEXT OF KIN	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH		79. TIME OF DEATH		80. PLACE OF DEATH	
81. SIGNATURE OF PHYSICIAN		82. SIGNATURE OF REGISTRAR		83. SIGNATURE OF WITNESS		84. SIGNATURE OF DECEASED		85. SIGNATURE OF NEXT OF KIN	
86. DATE OF DEATH		87. TIME OF DEATH		88. PLACE OF DEATH		89. TIME OF DEATH		90. PLACE OF DEATH	
91. SIGNATURE OF PHYSICIAN		92. SIGNATURE OF REGISTRAR		93. SIGNATURE OF WITNESS		94. SIGNATURE OF DECEASED		95. SIGNATURE OF NEXT OF KIN	
96. DATE OF DEATH		97. TIME OF DEATH		98. PLACE OF DEATH		99. TIME OF DEATH		100. PLACE OF DEATH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7297

CERTIFICATE OF DEATH

Reg. Dist. No. 07249

1. PLACE OF DEATH a. COUNTY Prince GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. of COLUMBIA b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL UPPER MARLBORO				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS ANACOSTIA WASH 25 DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 5 DOA USAFH ANDREWS AAFB				d. STREET ADDRESS UNKNOWN			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES BARTLETT ORMSBEE				4. DATE OF DEATH Month Day Year JUNE 5 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 SEPT 1939	
9. AGE (In years last birthday) 20 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILITARY SERVICE		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles ORMSBEE				14. MOTHER'S MAIDEN NAME Beulah (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] YES JAN. 13, 1959				16. SOCIAL SECURITY NO. 372-38-4393			
17. INFORMANT Address Naval Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SKULL FRACTURE DUE TO AUTOMOBILE ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile which left road and struck tree.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:15 JUN 5 19 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET	
				20f. (City or town) UPPER MARLBORO		(County) P.G. (State) MD	
21. I certify that I attended the deceased from DOA, 19 to 19, that I last saw the deceased alive on 5 JUNE, 19 60, and that death occurred at 3:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert C. Burkholder, USAF (MC) USAF HOSPITAL ANDREWS 6-6-60 ANDREWS AFB WASH 25 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				22b. DATE THEREOF 6-7-60		22c. NAME OF CEMETERY OR CREMATORY Flint Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co., 1400 Chapin St., N.W., Wash DC				24a. REC'D BY REGISTRAR DATE JUN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

Prince George Co. Medical Examiner, Dr. Boyd, notified and waived jurisdiction.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The following is a list of the names of the persons who have been admitted to the hospital since the last report was made.



2. The following is a list of the names of the persons who have been discharged from the hospital since the last report was made.

PATIENT'S NAME		DATE OF BIRTH		DATE OF ADMISSION		DATE OF DISCHARGE		REMARKS	
J. H. Smith		1890-01-15		1915-03-10		1915-04-20		Recovered from illness.	
M. J. Brown		1885-02-20		1915-03-15		1915-05-10		Improved, but still weak.	
W. R. Jones		1895-03-05		1915-03-20		1915-06-05		Discharged after treatment.	
A. L. White		1880-04-10		1915-04-01		1915-07-15		Long stay due to chronic condition.	
T. G. Black		1892-05-25		1915-04-10		1915-08-01		Discharged on medical advice.	
K. M. Green		1888-06-15		1915-04-25		1915-09-10		Discharged after surgery.	
N. P. Hall		1898-07-01		1915-05-05		1915-10-01		Discharged after long illness.	
B. C. King		1882-08-10		1915-05-15		1915-11-05		Discharged after treatment.	
F. D. Lee		1893-09-20		1915-06-01		1915-12-01		Discharged after surgery.	
G. E. Miller		1887-10-05		1915-06-10		1916-01-01		Discharged after long stay.	
H. F. Wilson		1891-11-15		1915-06-20		1916-02-01		Discharged after treatment.	
I. G. Young		1884-12-01		1915-07-05		1916-03-01		Discharged after surgery.	
J. K. Adams		1896-01-10		1915-07-15		1916-04-01		Discharged after long illness.	
L. M. Baker		1881-02-25		1915-07-25		1916-05-01		Discharged after treatment.	
O. N. Carter		1894-03-15		1915-08-05		1916-06-01		Discharged after surgery.	
P. Q. Davis		1886-04-20		1915-08-15		1916-07-01		Discharged after long stay.	
R. S. Evans		1897-05-05		1915-08-25		1916-08-01		Discharged after treatment.	
S. T. Foster		1883-06-10		1915-09-05		1916-09-01		Discharged after surgery.	
U. V. Gibson		1899-07-20		1915-09-15		1916-10-01		Discharged after long illness.	
V. W. Harris		1889-08-25		1915-10-05		1916-11-01		Discharged after treatment.	
X. Y. Ingram		1893-09-10		1915-10-15		1916-12-01		Discharged after surgery.	
Y. Z. Jordan		1885-10-20		1915-11-05		1917-01-01		Discharged after long stay.	
Z. A. Keller		1891-11-25		1915-11-15		1917-02-01		Discharged after treatment.	
A. B. Lewis		1887-12-05		1915-12-05		1917-03-01		Discharged after surgery.	
B. C. Martin		1895-01-15		1916-01-05		1917-04-01		Discharged after long illness.	
C. D. Nelson		1882-02-20		1916-01-15		1917-05-01		Discharged after treatment.	
D. E. Owen		1898-03-25		1916-02-05		1917-06-01		Discharged after surgery.	
E. F. Parker		1884-04-10		1916-02-15		1917-07-01		Discharged after long stay.	
F. G. Quinn		1892-05-20		1916-03-05		1917-08-01		Discharged after treatment.	
G. H. Roberts		1886-06-25		1916-03-15		1917-09-01		Discharged after surgery.	
H. I. Scott		1894-07-10		1916-04-05		1917-10-01		Discharged after long illness.	
I. J. Taylor		1881-08-20		1916-04-15		1917-11-01		Discharged after treatment.	
J. K. Underhill		1896-09-25		1916-05-05		1918-01-01		Discharged after surgery.	
K. L. Vance		1883-10-10		1916-05-15		1918-02-01		Discharged after long stay.	
L. M. Ward		1899-11-20		1916-06-05		1918-03-01		Discharged after treatment.	
M. N. Webb		1887-12-25		1916-06-15		1918-04-01		Discharged after surgery.	
N. O. Wright		1893-01-10		1916-07-05		1918-05-01		Discharged after long illness.	
O. P. Young		1885-02-20		1916-07-15		1918-06-01		Discharged after treatment.	
P. Q. Zeller		1891-03-25		1916-08-05		1918-07-01		Discharged after surgery.	
Q. R. Adams		1889-04-10		1916-08-15		1918-08-01		Discharged after long stay.	
R. S. Baker		1895-05-20		1916-09-05		1918-09-01		Discharged after treatment.	
S. T. Carter		1882-06-25		1916-09-15		1918-10-01		Discharged after surgery.	
T. U. Davis		1898-07-10		1916-10-05		1918-11-01		Discharged after long illness.	
U. V. Evans		1884-08-20		1916-10-15		1919-01-01		Discharged after treatment.	
V. W. Foster		1892-09-25		1916-11-05		1919-02-01		Discharged after surgery.	
W. X. Gibson		1886-10-10		1916-11-15		1919-03-01		Discharged after long stay.	
X. Y. Harris		1894-11-20		1916-12-05		1919-04-01		Discharged after treatment.	
Y. Z. Ingram		1881-12-25		1917-01-05		1919-05-01		Discharged after surgery.	
Z. A. Keller		1896-01-10		1917-01-15		1919-06-01		Discharged after long illness.	
A. B. Lewis		1883-02-20		1917-02-05		1919-07-01		Discharged after treatment.	
B. C. Martin		1899-03-25		1917-02-15		1919-08-01		Discharged after surgery.	
C. D. Nelson		1887-04-10		1917-03-05		1919-09-01		Discharged after long stay.	
D. E. Owen		1893-05-20		1917-03-15		1919-10-01		Discharged after treatment.	
E. F. Parker		1885-06-25		1917-04-05		1919-11-01		Discharged after surgery.	
F. G. Quinn		1891-07-10		1917-04-15		1920-01-01		Discharged after long illness.	
G. H. Roberts		1889-08-20		1917-05-05		1920-02-01		Discharged after treatment.	
H. I. Scott		1895-09-25		1917-05-15		1920-03-01		Discharged after surgery.	
I. J. Taylor		1882-10-10		1917-06-05		1920-04-01		Discharged after long stay.	
J. K. Underhill		1898-11-20		1917-06-15		1920-05-01		Discharged after treatment.	
K. L. Vance		1884-12-25		1917-07-05		1920-06-01		Discharged after surgery.	
L. M. Ward		1892-01-10		1917-07-15		1920-07-01		Discharged after long illness.	
M. N. Webb		1886-02-20		1917-08-05		1920-08-01		Discharged after treatment.	
N. O. Wright		1894-03-25		1917-08-15		1920-09-01		Discharged after surgery.	
O. P. Young		1881-04-10		1917-09-05		1920-10-01		Discharged after long stay.	
P. Q. Zeller		1896-05-20		1917-09-15		1920-11-01		Discharged after treatment.	
Q. R. Adams		1883-06-25		1917-10-05		1920-12-01		Discharged after surgery.	
R. S. Baker		1899-07-10		1917-10-15		1921-01-01		Discharged after long illness.	
S. T. Carter		1887-08-20		1917-11-05		1921-02-01		Discharged after treatment.	
T. U. Davis		1893-09-25		1917-11-15		1921-03-01		Discharged after surgery.	
U. V. Evans		1885-10-10		1917-12-05		1921-04-01		Discharged after long stay.	
V. W. Foster		1891-11-20		1918-01-05		1921-05-01		Discharged after treatment.	
W. X. Gibson		1889-12-25		1918-02-05		1921-06-01		Discharged after surgery.	
X. Y. Harris		1895-01-10		1918-02-15		1921-07-01		Discharged after long illness.	
Y. Z. Ingram		1882-02-20		1918-03-05		1921-08-01		Discharged after treatment.	
Z. A. Keller		1898-03-25		1918-03-15		1921-09-01		Discharged after surgery.	
A. B. Lewis		1884-04-10		1918-04-05		1921-10-01		Discharged after long stay.	
B. C. Martin		1892-05-20		1918-04-15		1921-11-01		Discharged after treatment.	
C. D. Nelson		1886-06-25		1918-05-05		1921-12-01		Discharged after surgery.	
D. E. Owen		1894-07-10		1918-05-15		1922-01-01		Discharged after long illness.	
E. F. Parker		1881-08-20		1918-06-05		1922-02-01		Discharged after treatment.	
F. G. Quinn		1896-09-25		1918-06-15		1922-03-01		Discharged after surgery.	
G. H. Roberts		1883-10-10		1918-07-05		1922-04-01		Discharged after long stay.	
H. I. Scott		1899-11-20		1918-07-15		1922-05-01		Discharged after treatment.	
I. J. Taylor		1887-12-25		1918-08-05		1922-06-01		Discharged after surgery.	
J. K. Underhill		1893-01-10		1918-08-15		1922-07-01		Discharged after long illness.	
K. L. Vance		1885-02-20		1918-09-05		1922-08-01		Discharged after treatment.	
L. M. Ward		1891-03-25		1918-09-15		1922-09-01		Discharged after surgery.	
M. N. Webb		1889-04-10		1918-10-05		1922-10-01		Discharged after long stay.	
N. O. Wright		1895-05-20		1918-10-15		1922-11-01		Discharged after treatment.	
O. P. Young		1882-06-25		1918-11-05		1922-12-01		Discharged after surgery.	
P. Q. Zeller		1898-07-10		1918-11-15		1923-01-01		Discharged after long illness.	
Q. R. Adams		1884-08-20		1918-12-05		1923-02-01		Discharged after treatment.	
R. S. Baker		1892-09-25		1919-01-05		1923-03-01		Discharged after surgery.	
S. T. Carter		1886-10-10		1919-01-15		1923-04-01		Discharged after long stay.	
T. U. Davis		1894-11-20		1919-02-05		1923-05-01		Discharged after treatment.	
U. V. Evans		1881-12-25		1919-02-15		1923-06-01		Discharged after surgery.	
V. W. Foster		1896-01-10		1919-03-05		1923-07-01		Discharged after long illness.	
W. X. Gibson		1883-02-20		1919-03-15		1923-08-01		Discharged after treatment.	
X. Y. Harris		1899-03-25		1919-04-05		1923-09-01		Discharged after surgery.	
Y. Z. Ingram		1887-04-10		1919-04-15		1923-10-01		Discharged after long stay.	
Z. A. Keller		1893-05-20		1919-05-05		1923-11-01		Discharged after treatment.	
A. B. Lewis		1885-06-25		1919-05-15		1923-12-01		Discharged after surgery.	
B. C. Martin		1891-07-10		1919-06-05		1924-01-01		Discharged after long illness.	
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E. F. Parker		1882-10-10		1919-07-15		1924-04-01		Discharged after long stay.	
F. G. Quinn		1898-11-20		1919-08-05		1924-05-01		Discharged after treatment.	
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K. L. Vance		1881-04-10		1919-10-15		1924-10-01		Discharged after long stay.	
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N. O. Wright		1899-07-10		1920-01-05		1925-01-01		Discharged after long illness.	
O. P. Young		1887-08-20		1920-01-15		1925-02-01		Discharged after treatment.	
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R. S. Baker		1891-11-20		1920-03-05		1925-05-01		Discharged after treatment.	
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Y. Z. Ingram		1886-06-25		1920-06-15		1925-12-01		Discharged after surgery.	
Z. A. Keller		1894-07-10		1920-07-05		1926-01-01		Discharged after long illness.	
A. B. Lewis		1881-08-20		1920-07-15		1926-02-01		Discharged after treatment.	
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H. I. Scott		1891-03-25		1920-11-05		1926-09-01		Discharged after surgery.	
I. J. Taylor		1889-04-10		1920-11-15		1926-10-01		Discharged after long stay.	
J. K. Underhill		1895-05-20		1920-12-05		1926-11-01		Discharged after treatment.	
K. L. Vance		1882-06-25		1921-01-05		1927-01-01		Discharged after surgery.	
L. M. Ward		1898-07-10		1921-01-15		1927-02-01		Discharged after long illness.	
M. N. Webb		1884-08-20		1921-02-05		1927-03-01		Discharged after treatment.	
N. O. Wright		1892-09-25		1921-02-15		1927-04-01		Discharged after surgery.	
O. P. Young		1886-10-10		1921-03-05		1927-05-01		Discharged after long stay.	
P. Q. Zeller		1894-11-20		1921-03-15		1927-06-01		Discharged after treatment.	
Q. R. Adams		1881-12-25		1921-04-05		1927-07-01		Discharged after surgery.	
R. S. Baker		1896-01-10		1921-04-15		1927-08-01		Discharged after long illness.	
S. T. Carter		1883-02-20</							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7235

CERTIFICATE OF DEATH

Reg. Dist. No.

07250

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 36 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 4950 - Annapolis Road							
3. NAME OF DECEASED (Type or print) First Middle Last Rose Anna Osterman				4. DATE OF DEATH Month Day Year June 23 - 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/4/1886	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired Naval Gun Factory				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Handy				14. MOTHER'S MAIDEN NAME Mary Jane Coombs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
INFORMANT May C. Puckett				4403 Van Buren st. University Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <i>myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 36 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/21 , 19 60 , to 6/23 , 19 60 , that I last saw the deceased alive on 6/22 , 19 60 , and that death occurred at 5:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4410 74th Ave 6/23/60 DATE SIGNED ACTUAL SIGNATURE <i>[Signature]</i> M.D. F.E. MUSSER M.D. Beltsville, Md. PHYSICIAN'S NAME (Type) F.E. MUSSER M.D. Beltsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/25/1960			
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery				22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home</i> ADDRESS 3200 - R.I. AVE. Mt. Rainier, Md.				24a. REC'D BY REGISTRAR DATE JUN 27 '60			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

MEDICAL CERTIFICATION

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George Henry

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07251

Reg. Dist. No.

7236

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Beaver Heights		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5205 Addison Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First David Middle Outlaw Last Outlaw			4. DATE OF DEATH Month June Day 8 Year 19 60		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-13	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe layer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) N. Carolina	
13. FATHER'S NAME David Outlaw			14. MOTHER'S MAIDEN NAME Fannie Gilliam		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2		17. INFORMANT Shirley Outlaw; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9/10-5 DUE TO Crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed chest DUE TO (c) Crushed chest					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was working in a ditch when side bank gave way covering deceased.					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was working in a ditch when side bank gave way covering deceased.			
20c. TIME OF INJURY Month, Day, Year 10-20-60 Hour 6-8 a. m. 1960		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Glen Arden Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 8, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-12-60		22b. DATE THEREOF 6-12-60		22c. NAME OF CEMETERY OR CREMATORY Merryhill N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington		ADDRESS 4925 Deane Ave NE.		24a. REC'D BY REGISTRAR DATE JUN 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07252**

7237

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Pr. Geo. b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 District Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7400 Walker Mill Road			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Robert Last Patterson				4. DATE OF DEATH Month June Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-00		9. AGE (In years last birthday) 60 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None True River		10b. KIND OF BUSINESS OR INDUSTRY Howat Concrete Co.		11. BIRTHPLACE (State or foreign country) Texas			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1918-1934		17. INFORMANT Address Mary Ruth Patterson; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> 442X PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ (b) _____ DUE TO _____ (c) _____ </div> <div style="width: 65%;"> Acute congestive heart failure Cardiovascular renal disease </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 12, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/16/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) Arlington, Va.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 517-11th St. S.E. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 14 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Hunt							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

2231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: <u>JOHN J. SMITH</u></p>		<p>2. SEX: <u>Male</u></p>	
<p>3. AGE: <u>45</u></p>		<p>4. DATE OF BIRTH: <u>1910</u></p>	
<p>5. PLACE OF BIRTH: <u>NEW YORK</u></p>		<p>6. OCCUPATION: <u>Teacher</u></p>	
<p>7. MARITAL STATUS: <u>Married</u></p>		<p>8. NUMBER OF DECEASED: <u>1</u></p>	
<p>9. PLACE OF DEATH: <u>Home</u></p>		<p>10. TIME OF DEATH: <u>10:00 AM</u></p>	
<p>11. CAUSE OF DEATH: <u>Heart Disease</u></p>		<p>12. MANNER OF DEATH: <u>Natural</u></p>	
<p>13. SIGNATURE OF EXAMINER: <u>[Signature]</u></p>		<p>14. DATE: <u>1955</u></p>	
<p>15. PLACE: <u>Baltimore, Md.</u></p>		<p>16. COUNTY: <u>Baltimore</u></p>	
<p>17. STATE: <u>Md.</u></p>		<p>18. ZIP CODE: <u>21201</u></p>	
<p>19. MEDICAL HISTORY: <u>None</u></p>		<p>20. SOCIAL HISTORY: <u>None</u></p>	
<p>21. PHYSICAL EXAMINATION: <u>None</u></p>		<p>22. LABORATORY EXAMINATION: <u>None</u></p>	
<p>23. POST-MORTEM EXAMINATION: <u>None</u></p>		<p>24. OTHER NOTES: <u>None</u></p>	

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the funeral director, may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7238

CERTIFICATE OF DEATH

07253

Item 7 rilm0253 6-8-60 et

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC (P.O. Zone 27)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 1 5105 N Street, SE	
3. NAME OF DECEASED (Type or print) First Middle Last Rev. Otto Penter		4. DATE OF DEATH Month Day Year June 1 19 60	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-88
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Minister		10b. KIND OF BUSINESS OR INDUSTRY Protestant	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Penter		14. MOTHER'S MAIDEN NAME Theresa (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 289-01-9960	
17. INFORMANT Kathryn C. Penter-#2d. Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Broncho pneumonia (b) Cerebellar hemorrhage. (c) Arterio sclerotic heart disease. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Carcinoma of the Pancreas.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 26, 1960, to JUNE 1, 1960, that (I) (we) last saw the deceased alive on JUNE 1, 1960, and that death occurred at 8:25 pm from the causes and on the date stated above.			
22a. SIGNATURE Charles C. Hageage		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES C HAGEAGE		22d. ADDRESS CHEVERLY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-4-60	
23c. NAME OF CEMETERY OR CREMATOR Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan Inc		25a. REC'D BY REGISTRAR DATE JUN 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

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Item 14 Film G265 6-28-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

07254

1. PLACE OF DEATH a. COUNTY <u>Brandywine</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prinseco</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07</u>	
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Maryland</u>		d. STREET ADDRESS <u>Woodlynn Rd. Clinton Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Pinkney</u> Middle <u>THOMAS</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Prinseco</u>		12. CITIZEN OF WHAT COUNTRY? <u>Prinseco</u>	
13. FATHER'S NAME <u>Henson Pinkney</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Skinner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Rebecca Brown Brandywine Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS 6 YRS</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>60</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred R. Lapin</u> M.D.		ADDRESS (Street, city or town, state) <u>Clinton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		DATE SIGNED <u>6/9/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>	22d. LOCATION (City, town, or county) (State) <u>Brandywine Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Kelson</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Clinton S. Hines</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7239

CERTIFICATE OF DEATH

Reg. Dist. No.

07255

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad Sacorda Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET BEATRICE RAHN</u>				4. DATE OF DEATH Month Day Year <u>June 18 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 31, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John James Caridon</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett Conlon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>husband</u>				Address <u>Cheverly, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno CARCINOMA OF COLON</u> DUE TO (c) <u>153.8</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>6 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1955</u> to <u>June 18 1960</u> that I last saw the deceased alive on <u>June 18 1960</u> and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Penay ST</u> DATE SIGNED <u>6/18/60</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>				M.D. <u>MT RAINIER MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

42.

2

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7240

07256

1. PLACE OF DEATH a. COUNTY Prince George County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b <i>Week on arm</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Capital Heights d. STREET ADDRESS 16321 Central Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) EARL WILSON RANDALL		4. DATE OF DEATH Month June Day 3 Year 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1930		9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Plumbing				11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME William Franklin Randall				14. MOTHER'S MAIDEN NAME Thelma Shane				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 578-36-4404				17. INFORMANT June Randall, Father, home			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) occupant fault that ran off road and struck															
20c. TIME OF INJURY Month, Day, Year 6-3 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Country				20f. (City or town) (County) (State) Farmstead PG MD							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.				DATE SIGNED June 3, 1960.				Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 6, 1960				22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland							
23. FUNERAL DIRECTOR W3 W. CHAMBERS CO.,				ADDRESS Riverdale, Maryland.				24a. REC'D BY REGISTRAR JUN 8 '60				24b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i>							

28

1

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7192 CERTIFICATE OF DEATH

Reg. Dist. No. 07257

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4531 Rowalt Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
3. NAME OF DECEASED (Type or print) Francis Marion Ray		d. STREET ADDRESS 14231 Rowalt Dr	
4. DATE OF DEATH June 22 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 19-1869
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer and Publisher		10b. KIND OF BUSINESS OR INDUSTRY Tennessee	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME D B Ray		14. MOTHER'S MAIDEN NAME Marion James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Elizabeth M Ray		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Failure DUE TO (c) Chronic-sclerotic heart dis		INTERVAL BETWEEN ONSET AND DEATH 5 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 , 19 to June 1960 , that I last saw the deceased alive on June 8 1960 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4713 Cherry St College Park Md DATE SIGNED 6/24/60			
ACTUAL SIGNATURE W. L. Etienne		M.D. W. L. Etienne	
PHYSICIAN'S NAME (Type) W. L. Etienne		College Park Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR JUN 27 '60		24b. REGISTRAR'S SIGNATURE William S. K...	

07551

CERTIFICATE OF DEATH

7193



Prince George's

Princess Anne

Prince George's

College Hill, Md.

College Hill, Md.

College Hill, Md.

College Hill, Md.

Prince William

College Hill, Md.

U.S.A.

Princess Anne

College Hill, Md.

College Hill, Md.

Princess Anne

College Hill, Md.

Handwritten notes and signatures in the center of the page, including names like "Prince William" and "Princess Anne".

Princess Anne

Prince George's

College Hill, Md.

College Hill, Md.

Princess Anne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7260

CERTIFICATE OF DEATH

Reg. Dist. No.

07258

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b Laurel General Hospital d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage d. STREET ADDRESS Pox 261 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louise Redmiles				4. DATE OF DEATH Month Day Year June 19 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1909	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Same			
13. FATHER'S NAME Hugh Barton				14. MOTHER'S MAIDEN NAME Sarah Harrington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) not				16. SOCIAL SECURITY NO. not		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO 633 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pelvic Abscess DUE TO 48 hrs (c) Post-operative - Total hysterectomy 48 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) not							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Laurel				20g. (County) Howard		20h. (State) Md	
21. I certify that I attended the deceased from 6/11 , 19 60 , to 6/19 , 19 60 , that I last saw the deceased alive on 6/19/60 , and that death occurred at 3 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 150 Wash Blvd DATE SIGNED 6/21/60							
ACTUAL SIGNATURE Joseph B. Sindelar				PHYSICIAN'S NAME (Type) Joseph B. Sindelar, M.D. 150 Washington Blvd., Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/60		22c. NAME OF CEMETERY OR CREMATORY Long Hill Cem.		22d. LOCATION (City, town, or county) (State) Laurel, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Witt Sanderson				24a. REC'D BY REGISTRAR JUN 24 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hurd	

CERTIFICATE OF DEATH

1900

Reg. No. 100

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF CLERGYMAN</p> <p>21. SIGNATURE OF JUDGE</p> <p>22. SIGNATURE OF JURY</p> <p>23. SIGNATURE OF COURT</p> <p>24. SIGNATURE OF STATE</p> <p>25. SIGNATURE OF UNION</p> <p>26. SIGNATURE OF COUNTRY</p> <p>27. SIGNATURE OF WORLD</p> <p>28. SIGNATURE OF UNIVERSE</p> <p>29. SIGNATURE OF GOD</p> <p>30. SIGNATURE OF ALL</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF CLERGYMAN</p> <p>21. SIGNATURE OF JUDGE</p> <p>22. SIGNATURE OF JURY</p> <p>23. SIGNATURE OF COURT</p> <p>24. SIGNATURE OF STATE</p> <p>25. SIGNATURE OF UNION</p> <p>26. SIGNATURE OF COUNTRY</p> <p>27. SIGNATURE OF WORLD</p> <p>28. SIGNATURE OF UNIVERSE</p> <p>29. SIGNATURE OF GOD</p> <p>30. SIGNATURE OF ALL</p>
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6, 23 FilmG265 6-21-60 et

CERTIFICATE OF DEATH

Reg. Dist. 07259

7241

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian	
c. LENGTH OF STAY IN 1b 8 hrs		d. STREET ADDRESS Rt. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irving Middle Riggs Last Riggs		4. DATE OF DEATH Month June Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Feb 1905
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Riggs		14. MOTHER'S MAIDEN NAME Louise Creek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Matilda Riggs Lothian Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Final diagnosis deferred pending microscopic examination. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) microscopic examination. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12 , 19 60 , to June 13 , 19 60 , that I last saw the deceased alive on June 12 , 19 60 , and that death occurred at 6,25 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lothian Maryland DATE SIGNED 6-12-60			
ACTUAL SIGNATURE Arthur S. Kneib M.D.		PHYSICIAN'S NAME (Type) Arthur S. Kneib	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/18/60	22c. NAME OF CEMETERY OR CREMATORY Moses Cemetery	22d. LOCATION (City, town, or county) (State) Anne A undel County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE F.K. Stewart		24a. REC'D BY REGISTRAR JUN 15 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kneib	

077

2

3717-3864 Ave
College City

1943

Personnel Section

1. Mr. [Name] [Title]

2. Mr. [Name] [Title]

3. Mr. [Name]

4. Mr. [Name]

5. Mr. [Name]

6. Mr. [Name]

7. Mr. [Name]

8. Mr. [Name]

9. Mr. [Name]

10. Mr. [Name]

11. Mr. [Name]

12. Mr. [Name]

13. Mr. [Name]

14. Mr. [Name]

15. Mr. [Name]

16. Mr. [Name]

17. Mr. [Name]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7242

CERTIFICATE OF DEATH

07260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carolyn Middle Roberts Last				4. DATE OF DEATH Month June Day 10 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Dec. 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Eugene Elberts				14. MOTHER'S MAIDEN NAME Janet Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Wm W Roberts				Address Bladensburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Bleeding - Toxic and terminal 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Insufficiency							INTERVAL BETWEEN ONSET AND DEATH 23 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-9 , 19 60 , to 6-10 , 19 60 , that I last saw the deceased alive on 6-10 , 19 60 , and that death occurred 5:18 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St. June 10 - 1960 DATE SIGNED							
ACTUAL SIGNATURE Waldo B. Moyers M.D.				PHYSICIAN'S NAME (Type) Dr. W.B. Moyers MD.			
22a. BURIAL, CREMATION, REINTERMENT, etc. (Type and date) Burial June 14, 1960				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St Barnabas Cemetery	
22d. LOCATION (City, town, or county) (State) Leeland Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. House							

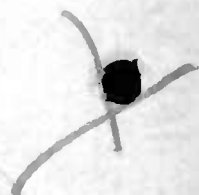
1 **X**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07261

7261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. LENGTH OF STAY IN 1b adm 6-16-1960			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY EMMA ROLOPH				4. DATE OF DEATH 6 19 1960			
5. SEX female		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 1865	
9. AGE (In years last birthday) 95		10. UNDER 1 YEAR Months		11. UNDER 24 HRS. Days		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				14. KIND OF BUSINESS OR INDUSTRY MARYLAND			
15. BIRTHPLACE (State or foreign country) MARYLAND				16. CITIZEN OF WHAT COUNTRY? U. S. A.			
17. FATHER'S NAME GEORGE TAYLOR				18. MOTHER'S MAIDEN NAME MARGARET LONG			
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				20. SOCIAL SECURITY NO. NONE			
21. INFORMANT hosp. Records LAUREL SANITARIUM				22. ADDRESS LAUREL SANITARIUM			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac fibrillation (433.1) DUE TO (b) arteriosclerotic heart disease (422.1) DUE TO (c) (422.1) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility (b) Malnutrition 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-16-1960 to 6-19-1960 that I last saw the deceased alive on 6-19-1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
22. ACTUAL SIGNATURE Erika P. Kraemer M.D. LAUREL SANITARIUM 6-19-60							
23. PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER LAUREL MARYLAND							
24. BURIAL, CREMATION, REMOVAL (Specify) Burial June 21, 1960							
25. NAME OF CEMETERY OR CREMATORY Centerville Cemetery							
26. LOCATION (City, town, or county) (State) Centerville, Maryland							
27. FUNERAL DIRECTOR'S SIGNATURE John H. Batten Jr. of Batten Bros. Centerville, Maryland							
28. REC'D BY REGISTRAR DATE JUN 22 '60							
29. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7193

CERTIFICATE OF DEATH

Reg. Dist. No.

07262

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Pro George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park Md		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8704 Baltimore ave			d. STREET ADDRESS 1 8704 Baltimore avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH HUNTER ROSE			4. DATE OF DEATH Month Day Year June 3, 1960 19		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 17, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Matiance		10b. KIND OF BUSINESS OR INDUSTRY Real Estate co		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Joseph H. Rose			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			14. MOTHER'S MAIDEN NAME Caroline Greenlaw		
17. INFORMANT Mary C Rose			Address College Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterovascular generaliz 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tyelomachitis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 3-12, 1959, to 5-17, 1960, that I last saw the deceased alive on 5-17, 1960, and that death occurred at M, from the causes and on the date stated above.					
ACTUAL SIGNATURE D. R. Purdie		M.D. 4404 Queensbury Rd. Riverdale Md.		DATE SIGNED 6/13/60	
PHYSICIAN'S NAME (Type) D. R. Purdie		Riverdale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 7, 1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Knecht

7198

CERTIFICATE OF DEATH

Reg. Dis. No. 07263

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pri. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>65 Riverdale, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Manor, 4922 LaSalle Rd.</i>		1 d. STREET ADDRESS <i>6111 Baltimore Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle Last <i>Sanders</i>		4. DATE OF DEATH Month <i>June</i> Day <i>6</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-5-1869</i>
9. AGE (In years last birthday) <i>90 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Siggamala, Sweden</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Carl Bengtson</i>	
14. MOTHER'S MAIDEN NAME <i>Christine Nelson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		INFORMANT Address <i>Hyattsville, Md.</i> <i>St. Bernadette Joseph 4922 LaSalle Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Infarction</i> 463X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Phlebotrombosis</i> DUE TO (c) <i>Post operative thigh amputation 6 wks</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Sensitivity Secubiti</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 19 <i>60</i> , to <i>present</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>6 June</i> , 19 <i>60</i> , and that death occurred at <i>6:20</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John H. Bayly</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>1835 Eye N.W. 6 June 60</i>	
PHYSICIAN'S NAME (Type) <i>John H. Bayly</i>		<i>WASH. G. D. C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 9, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 8 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

5

CERTIFICATE OF DEATH

Reg. Dist. No.

07264

7243

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES G. SASSCER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor of Medicine</u>		10b. KIND OF BUSINESS OR INDUSTRY (Own) <u>Gen. Practice</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Sasscer</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Claggett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT Address <u>Rosalie Sasscer-Same as Item 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease 1 yr</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>60</u> , to <u>6/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>60</u> , and that death occurred at <u>10:57</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>6/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Norman Donat Comeau</u>		<u>MT Rainier Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

100

June 22, 1900

San Francisco

John A. Smith

Residence - 1234 Main St.

Office of Registrar

San Francisco

1

2/27/80

John A. Smith

Residence - 1234 Main St.

CERTIFICATE OF DEATH

Reg. Dist. No.

07265

7299

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGE</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>VIRGINIA</i> b. COUNTY <i>ARLINGTON</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS, RURAL</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ARLINGTON</i>		
c. LENGTH OF STAY IN 1b <i>31 DAYS</i>			83X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF HOSPITAL ANDREWS</i>			d. STREET ADDRESS <i>3801 24th St N</i>		
3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>FREDERICK</i> Last <i>SETCHELL</i>			4. DATE OF DEATH Month <i>JUNE</i> Day <i>13</i> Year <i>1960</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>CAU</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9 AUG 1913</i>		9. AGE (In years last birthday) <i>46</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>USAF RET</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>ILLINOIS</i>	
13. FATHER'S NAME <i>FREDERICK J. SETCHELL</i>			14. MOTHER'S MAIDEN NAME <i>WINIFRED Noble</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES 1939-1960</i>		16. SOCIAL SECURITY NO. <i>339-01-7235</i>		INFORMANT Address <i>WIFE SAME AS #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable INTERCURRENT INFECTION</i> 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASTROCYTOMA Grade IV, recurrent</i> DUE TO (c) <i>2 years</i>					INTERVAL BETWEEN ONSET AND DEATH <i>4 DAYS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>13 June</i> , 1960, to <i>13 June</i> , 1960, that I last saw the deceased alive on <i>13 JUNE</i> , 1960, and that death occurred at <i>3154 M</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Andrew W. Butchko</i>		M.D. <i>USAF HOSPITAL ANDREWS</i>		DATE SIGNED <i>13 JUNE 1960</i>	
PHYSICIAN'S NAME (Type) <i>ANDREW W BUTCHKO, Capt, USAF MC</i>		<i>ANDREWS AFB WASHINGTON 25, D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 17, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>	
22d. LOCATION (City, town, or county) <i>Arlington Va.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lincoln Funeral Home</i>		ADDRESS <i>816 N. St. N. E. Wash</i>		24a. REC'D BY REGISTRAR <i>JUN 16 1960</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filled with the funeral director's signature. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1900
DEPT. OF HEALTH
Baltimore

1232

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

02881

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Date of Death	
123 Main St.		Teacher		Heart Disease		Jan 5, 1900	
Physician		Burial Place		Buried		Date of Burial	
Dr. Smith		St. Mary's		Yes		Jan 10, 1900	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No. 07266

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 3914 Newark Road	
3. NAME OF DECEASED (Type or print) John First Jacob Middle Simpson Last		4. DATE OF DEATH June Month 29 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 25, 1901
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Const. Building	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Simpson		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 161-12-0959	
17. INFORMANT Jessie M. Simpson Address (same as # 2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hyper sensitive cardiac muscular disease DUE TO Atrial Fibrillation (c) Atrial Fibrillation		INTERVAL BETWEEN ONSET AND DEATH 6-27-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-27 , 19 60 , to 6-29 , 19 60 that I last saw the deceased alive on 6-29 , 19 60 , and that death occurred at 4 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Hageage M.D.		ADDRESS (Street, city or town, state) 3717-38th Ave DATE SIGNED 6-30-60	
PHYSICIAN'S NAME (Type) Geo. J. Hageage		COLMAR MANOR MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS 4739 Balt. Ave, Hyattsville, Md.		24a. REC'D BY REGISTRAR JUL 5 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1968

Prison Service
Cemetery
Colonel Hunter

Prison Service General Hospital
2014 Newark Road

John Jacob Johnson
John Jacob Johnson
John Jacob Johnson

George Johnson
General Building
B. B. A.

John Johnson
101-12-0000
John Johnson (born 1912)

Handwritten notes:
John Johnson
Hypertension
Cerebral arteriosclerosis

2-27-68
2-27-68
2-27-68
2-27-68
2-27-68

Prison Service
John Johnson
John Johnson
John Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07267

7245

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Smith		4. DATE OF DEATH June 27 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/60
9. AGE (In years lost birthday) 12		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Oswald Smith		14. MOTHER'S MAIDEN NAME Eunice Oswald Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		18. Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 771.0 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Asphyxia DUE TO Terminal multiple Lungs Lacer. (c) Terminal multiple Lungs Lacer.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 16 19 60 to June 27 19 60 , that (I) (we) last saw the deceased alive on June 27 19 60 , and that death occurred at 6:10P from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Christensen		22b. DATE SIGNED 6/28/60	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.		22d. ADDRESS 6905 Baltimore Ave., College Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/60	
23c. NAME OF CEMETERY OR CREMATORY Gibbons Meth. Church		23d. LOCATION (City, town, or county) (State) Brandywine, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Stewart		25a. REC'D BY REGISTRAR DATE JUL 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		25c. ADDRESS 30 H Street, N.E.	

2077281XV2

0328

CERTIFICATE OF DEATH

1937

11

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07268

7246

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piscatoway- Clinton P.O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Joseph William Smith SR			4. DATE OF DEATH Month Day Year June 13 19 60		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-26-1908	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles S. Smith		14. MOTHER'S MAIDEN NAME Alberta Goshorn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.2		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Smith, Jr. Address 826 50th Avenue Capitol Heights, Washington-27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1960		22c. NAME OF CEMETERY OR INTERMENT PLACE Arlington National	
22d. LOCATION (City, town, or county) Arlington Virginia.		22e. (State)		22f. (City or town) (County) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.			24a. REC'D BY REGISTRAR DATE JUN 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

07269

7247

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07270

7300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>			
c. LENGTH OF STAY IN lb <u>6 yrs</u>				d. STREET ADDRESS <u>2817-Colebrook Dr SE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2817-Colebrook Dr SE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Stahl</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 6-1875</u>	
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Stahl</u>				14. MOTHER'S MAIDEN NAME <u>SARAH Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Goldie Walker</u> Address <u>2817-Colebrook Dr Hillcrest Hgts</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> DUE TO <u>465X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Massive right pleural effusion</u> DUE TO <u>2 weeks</u> (c) <u>Pulmonary infarction</u> DUE TO <u>3 weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>60</u> , to <u>6-2</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-1</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David S. Gordon</u> , M.D.				ADDRESS (Street, city or town, state) <u>5731 23rd Avenue SE</u> DATE SIGNED <u>6-2-60</u>			
PHYSICIAN'S NAME (Type) <u>David S. Gordon</u>				Address <u>Wash. 21, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Pleasant Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samson Bros.</u> ADDRESS <u>1661- Good Hope Rd SE Wash 20 25</u>				24a. REC'D BY REGISTRAR <u>JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

18

1

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of registrar		11. Signature of physician		12. Signature of coroner	
John Doe		Male		45		Jan 1, 1900		Boston, Mass.		Jan 1, 1945		Boston, Mass.		Heart disease		Natural		John Doe		John Doe		John Doe	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. County		19. District		20. Sub-district		21. Ward		22. Precinct		23. Signature of informant		24. Signature of registrar	
Jane Doe		Wife		123 Main St.		Boston		Mass.		Suffolk		North		East		South		West		Jane Doe		John Doe	
25. Name of funeral home		26. Address		27. City		28. State		29. County		30. District		31. Sub-district		32. Ward		33. Precinct		34. Signature of funeral home		35. Signature of registrar		36. Signature of physician	
Funeral Home		123 Main St.		Boston		Mass.		Suffolk		North		East		South		West		Funeral Home		John Doe		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7301

07271

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1722 Bay St., S. E., Apt 2			
3. NAME OF DECEASED (Type or print) First Florence Middle B. Last Stubblefield				4. DATE OF DEATH Month 6 Day 6 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/22/82	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (unemployed)				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Tenley				14. MOTHER'S MAIDEN NAME Liza Wheat			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with auricular fibrillation, decompensated DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active (18 months) Unimproved (Chemotherapy) died; pulmonary emphysema; pulmonary edema 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3/2 1959 to 6/6/ 1960 , that (I) (we) last saw the deceased alive on 6/6/ 1960 , and that death occurred at 2:00 A. M., from the causes and on the date stated above. 22a. SIGNATURE Moe Weiss M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 22b. DATE SIGNED 6/6/60							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 8-60		23b. DATE THEREOF June 8-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Seinthard Md	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		ADDRESS 1661- Good Hope Rd		25a. REC'D BY REGISTRAR SUN 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Wash DC DC SE

03731

CERTIFICATE OF DEATH

1301



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CERTIFICATE OF DEATH

Reg. Dist. No.

07272

7302

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 18 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS, WASH 25 DC		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 4287 6th ST SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KAREN Middle SUE Last SUTTON		4. DATE OF DEATH Month JUNE Day 14 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 MAY 1960
9. AGE (In years last birthday) 18		10. IF UNDER 1 YEAR Months 18	
11. IF UNDER 24 HRS. Days 9		12. Hours 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JAMES E SUTTON		14. MOTHER'S MAIDEN NAME BARBARA J HALLETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Leukemia DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 17 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 27 May , 19 60 , to 14 June , 19 60 , that I last saw the deceased alive on 14 June , 19 60 , and that death occurred at 1025 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE John A. Moore M.D. USAF HOSPITAL ANDREWS 14 JUNE 60 PHYSICIAN'S NAME (Type) JOHN A MOORE, MAJOR USAF (MC) ANDREWS AIR FORCE BASE, WASHINGTON 25, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 17, 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Russell Funeral Home		24a. REC'D BY REGISTRAR DATE JUN 16 '60	
ADDRESS 816 H St. N.E. Wash DC		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

VS A15 (4)
15M 9/58

Now

2050234XV4

CERTIFICATE OF DEATH

308

1937

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Signature of Medical Examiner		Signature of Police Officer		Signature of Undertaker	
Signature of Burial Officer		Signature of Cemetery Officer		Signature of Funeral Home	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of Synagogue		Signature of Mosque	
Signature of Other		Signature of Other		Signature of Other	

CERTIFICATE OF DEATH

Reg. Dist. No.

07273

7303

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7255 E. FORT FOOTE TERRACE</u>		d. STREET ADDRESS <u>17255 E. FORT FOOTE TERRACE</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ISABEL</u> Last <u>SWINDELLS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1899</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES C. BURY</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. KELLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ANNIE K. ARMSTRONG</u>		Address <u>7255 E FORT FOOTE TERR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>5 YRS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC DECOMPENSATION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 14, 1960</u> to <u>JUNE 29, 1960</u> , that I last saw the deceased alive on <u>JUNE 29, 1960</u> , and that death occurred at <u>9:35 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent J. Di Francesco</u> M.D.		ADDRESS (Street, city or town, state) <u>2436 L'ENFANT SQUARE, WASH 20 D.C.</u>	
PHYSICIAN'S NAME (Type) <u>VINCENT J. DI FRANCESCO</u>		DATE SIGNED <u>JUNE 29, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 1st - 60</u>	<u>Cedar Hill</u>	<u>Smithland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>1661 9th Hope Rd WASH DC</u>	
24a. REC'D BY REGISTRAR <u>JUN 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07274

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Henry Tass</u>		4. DATE OF DEATH <u>June 9 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>June 16, 1939</u>	9. AGE (in years last birthday) <u>20</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ex-Airman 2d class</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>Henry J. Tass</u>		14. MOTHER'S MAIDEN NAME <u>Minerva E. Cohill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>579-50-3272</u>	
17. INFORMANT <u>Mrs. Minerva E. Tass</u>		Address <u>4670 Homer Ave., Suitland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>acute Carbon Monoxide poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>973.1</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran here from exhaust into car</u>	
20c. TIME OF INJURY <u>6-9 1960</u>	20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Park Ave</u>	20f. (City or town) <u>Suitland</u> (County) <u>PG</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>6-9-60</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Burial June 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Virginia.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u> ADDRESS <u>Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEATH EXAMINER'S CERTIFICATE OF DEATH

20

Funeral Home 15, 1500 Arlington National
 Funeral Home, Inc.,
 Baltimore, Md.

7248

CERTIFICATE OF DEATH

07275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days 3 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Bradbury Heights, Md.		d. STREET ADDRESS 4804 V St. S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert		Middle R.		Last Thomas		4. DATE OF DEATH Month June 12		Day 12		Year 1960		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-93		9. AGE (In years lost birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) DC Gov't		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert R. Thomas		14. MOTHER'S MAIDEN NAME Margaret E. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		INFORMANT Elizabeth Notestine		Address 4804--V--St., SE Wash 27 DC		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch. Glor emu neffatus DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from June 6 , 19 60 , to June 12 , 19 60 , that I last saw the deceased alive on June 12 , 19 60 , and that death occurred at 8:15 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3717-38th Ave Cottage City Md		DATE SIGNED 6-12-60			
ACTUAL SIGNATURE George Hageage		M.D. 3717-38th Ave Cottage City Md		PHYSICIAN'S NAME (Type) Dr. George Hageage		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland Md.		23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bus Wash. D.C.	
24a. REC'D BY REGISTRAR JUN 14 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS 1661 14th St. N.E. Wash. D.C.		24d. DATE JUN 14 60		24e. ADDRESS 1661 14th St. N.E. Wash. D.C.		24f. DATE JUN 14 60		24g. ADDRESS 1661 14th St. N.E. Wash. D.C.		24h. DATE JUN 14 60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07837

CONFIDENTIAL

25

1

Handwritten signature

Handwritten notes and signatures at the bottom of the page, including dates like "June 12" and "June 13".

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7249

07276

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 613 10th St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Katherine		First		Middle		Last Thomas	
4. DATE OF DEATH June 26 1960		Month		Day		Year	
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 May 1968	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Bacon				14. MOTHER'S MAIDEN NAME Sarah Bacon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pelvic Abscess DUE TO (c) Perforated Appendix							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 1960 to JUNE 26 1960 , that (I) (we) last saw the deceased alive on June 26 1960 , and that death occurred at 7:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Dayton Watkins M.D.				22b. DATE, SIGNED 6/26/60			
22c. PHYSICIAN'S NAME (Type) DAYTON O. WATKINS				22d. ADDRESS 6304 Annapolis Rd. Beltsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6/29/60		23c. NAME OF CEMETERY OR CREMATORY St. Marks,		23d. LOCATION (City, town, or county) (State) Harman, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				25a. REC'D BY REGISTRAR DATE JUL 5 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House	

CERTIFICATE OF DEATH

1934

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 15 1889*
5. Place of birth: *New York City*
6. Date of death: *Dec 10 1934*
7. Place of death: *New York City*
8. Cause of death: *Heart disease*
9. Signature of physician: *Dr. J. H. Smith*
10. Signature of registrar: *W. H. Jones*
11. Signature of undertaker: *John Doe*
12. Signature of witness: *John Doe*
13. Signature of witness: *John Doe*
14. Signature of witness: *John Doe*
15. Signature of witness: *John Doe*
16. Signature of witness: *John Doe*
17. Signature of witness: *John Doe*
18. Signature of witness: *John Doe*
19. Signature of witness: *John Doe*
20. Signature of witness: *John Doe*

CHIEF CLERK

1934

7255

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			c. LENGTH OF STAY IN 1b 10 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Colmar Manor				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4101 Newton Street				d. STREET ADDRESS 4101 Newton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mittie Middle Rachel Last Tucker				4. DATE OF DEATH Month June Day 11 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1885			
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Benjamin F. Shipley				14. MOTHER'S MAIDEN NAME Mary Elizabeth Mulleneaux					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Julia C. Williams Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Thrombia DUE TO (b) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20 yrs.							INTERVAL BETWEEN ONSET AND DEATH 20 yrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 1, 1959 , to June 11, 1960 , that I last saw the deceased alive on June 3, 1960 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Belmeade Md DATE SIGNED June 11-1960 ACTUAL SIGNATURE C. D. CONNOR M.D. BELMEADE - MD - PHYSICIAN'S NAME (Type) C. D. CONNOR									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		6/14/60		Maple Lawn		Greentown Tennessee			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gracie sons Hyattsville Md				24a. REC'D BY REGISTRAR DATE JUN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7250

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 5457 Madison Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ARCHIE UNDERWOOD				4. DATE OF DEATH Month Day Year 6 2 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-83	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D C Gov't		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Underwood				14. MOTHER'S MAIDEN NAME Anna Munk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT John W Underwood		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.3 DUE TO Toxemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sanguine of the small intestine DUE TO Water ulcer of the small intestine (c) Water ulcer of the small intestine							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-19 , 19 59 , to 6-2 , 19 60 , that I last saw the deceased alive on 6-1 , 19 60 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. D. BAKER		ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. Md.				DATE SIGNED 6-2-60	
PHYSICIAN'S NAME (Type) R. D. BAKER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS HyattsVille, Md.		24a. REC'D BY REGISTRAR DATE JUN 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kimes			

43

CERTIFICATE OF DEATH

First Name

Initial

Last Name

Married Name

Age

Sex

Place of Birth

Place of Death

To

12-20-13

Time

Place

Death of (Name of Deceased) at (Place of Death)

John Smith

John Smith

John V. Smith, Physician

Dr.

Signature of Physician

John V. Smith, M.D.

John V. Smith, M.D.

Physician

John V. Smith, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines- Riverdale		c. LENGTH OF STAY IN 1b 14 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5703 64th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last Edmund George Van Gorden</div>		4. DATE OF DEATH Month June Day 15 Year 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinist		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Van Gordon		14. MOTHER'S MAIDEN NAME Frances Terry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 712-18-3043	
17. INFORMANT Paul Britt; East Pines- Riverdale		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED June 15, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 35	
RACE White		OCCUPATION Laborer		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH June 18, 1960		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		SIGNATURE OF EXAMINER [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF NEAREST RELATIVE [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]		SIGNATURE OF JURY [Signature]	
SIGNATURE OF DISTRICT ATTORNEY [Signature]		SIGNATURE OF CLERK [Signature]		SIGNATURE OF NOTARY [Signature]	

6

W. J. CHAMBERS CO., BALTIMORE, MD.
 Printed June 18, 1960 at the Maryland State Department of Health, Baltimore, Maryland.

7305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 15 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS, WASH 25 DC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle E Last WALKE		4. DATE OF DEATH Month JUNE Day 17 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 SEPTEMBER 1909
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALEXANDER C. WALKE		14. MOTHER'S MAIDEN NAME KATHERINE GRACE GLENN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 578-40-0921	
17. INFORMANT WIFE		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 15 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 16 JUNE, 1960 , to 17 JUNE, 1960 , that I last saw the deceased alive on 17 JUNE, 1960 , and that death occurred at 4:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles S. Moon		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS	
PHYSICIAN'S NAME (Type) CHARLES S. MOON, CAPT USAF (MC)		DATE SIGNED 17 JUNE 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 20, 1960	22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens
22d. LOCATION (City, town, or county) ARLINGTON		(State) VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE EVERLY-WHEATLEY		24. REGISTRAR'S SIGNATURE ALEXANDRIA, VA	
24a. ADDRESS 1500 W. BRADDOCK ST.		24b. DATE JUN 21 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

VS A15 (4)
ISM 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14

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1305

1305

07304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07281

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 MT RANIER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL			d. STREET ADDRESS 1 4016 29th ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) CORA First L Middle WALL Last			4. DATE OF DEATH JUNE 23 1960 Month JUNE Day 23 Year 1960		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-14-97		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charlie H. Hodge		
14. MOTHER'S MAIDEN NAME Mattie L. Renfrow			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. ----			17. INFORMANT Helen F. Beasley Address 3000 39th St. N.W. Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) 34keft INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis Heart Disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from JUNE 13, 1960 , to JUNE 13, 1960 , that (I) (we) last saw the deceased alive on June 13, 1960 , and that death occurred at 3:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Samuel J. N. Sugar M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 23, 1960			
22c. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR MD		22d. ADDRESS 4300 KAYWOOD DR MT RANIER, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/25/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City, town, or county) (State) Suitland, Md.		24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Address 2901 14th St. N.W. Washington 9, D.C.			
25a. REC'D BY REGISTRAR JUN 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

14524

CERTIFICATE OF DEATH

(M)

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PAINE

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7252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 4326 Rowalt Drive	
3. NAME OF DECEASED (Type or print) First Mildred Middle K. Last Wangler		4. DATE OF DEATH Month June Day 16 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H Keith		14. MOTHER'S MAIDEN NAME Martha M Garges	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John G Wangler		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 540.0 IMMEDIATE CAUSE (a) GI tumor in large intestine DUE TO (b) gastric ulcer DUE TO (c) gastric ulcer Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1960 to June 16, 1960 , that I last saw the deceased alive on June 15, 1960 , and that death occurred at 2:45 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Walcott L. Etienne		ADDRESS (Street, city or town, state) 4713 Berwyn Road	
PHYSICIAN'S NAME (Type) Dr. Walcott L. Etienne		M.D. College Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR JUN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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0722

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James Madison
College Park
Virginia

James Madison

James

James Madison

College Park

James

James

James Madison University

James Madison

James

James

May 28, 1902

own name

James

Washington D. C.

James H. Madison

James H. Madison

John G. Madison, College Park, Va.

and name

Handwritten signature and notes

June 18, 60

James Madison

College Park, Va.

James H. Madison

University of Virginia

James H. Madison

James H. Madison

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7199

CERTIFICATE OF DEATH

Reg. Dist. No. 07283

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor, 4922 LaSalle Road		d. STREET ADDRESS 3200 - 16th Street NW	
3. NAME OF DECEASED (Type or print) First Regina Middle C. Last Watkins		4. DATE OF DEATH Month June Day 1, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1888
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical-Supervisor		10b. KIND OF BUSINESS OR INDUSTRY U.S.Gov.Dept.Int.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicholas Watkins,		14. MOTHER'S MAIDEN NAME Mary Ann Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Sr. M. Bernedette Joseph, Carroll Manor.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary Thrombosis with Myocardial Infarction. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 4 weeks 5 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/18/1958, 19, to 6/1/1960, 19, that I last saw the deceased alive on 6/1/1960, 19, and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Collins		ADDRESS (Street, city or town, state) 322- H. Street, N.E.	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		DATE SIGNED 6/2/1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery,		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		ADDRESS Washington, D.C. 2224 Wis. Ave. N.W.	
24a. REC'D BY REGISTRAR JUN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07284

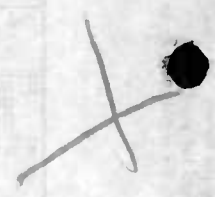
7306

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hill	c. LENGTH OF STAY IN 1b 9 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6398 Temple Hill Road		d. STREET ADDRESS 6398 Temple Hill Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Weil		4. DATE OF DEATH Month June Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1897
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick W. Weil	
14. MOTHER'S MAIDEN NAME Mary Slatford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I	
16. SOCIAL SECURITY NO. 578 09 4502		17. INFORMANT Mildred W. Weil; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Shotgun wound of chest (c) Shotgun wound of chest DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self inflicted wound.			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound.	
20c. TIME OF INJURY Month, Day, Year 6-15-60 Hour 2:00 P.M.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Temple Hill Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6-17-1960	
22c. NAME OF CEMETERY OR CREMATORY Washington NATL.		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR 1661- Cool Hope Rd SE WASH DC	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner	
John T. Jones		35		Male		White		June 15, 1950		10:30 AM		Home		Heart Disease		Natural		John T. Jones		John T. Jones	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Injury		Signature of Coroner		Signature of Medical Examiner	
1234 Main St.		Teacher		High School		Married		None		Occasional		Daily		None		None		John T. Jones		John T. Jones	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner	
June 15, 1915		Baltimore, Md.		June 10, 1950		June 12, 1950		June 15, 1950		10:30 AM		Home		Heart Disease		Natural		John T. Jones		John T. Jones	



7200

CERTIFICATE OF DEATH

07285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5512 Taylor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle L. Last Wheatley		4. DATE OF DEATH Month June Day 5 , Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1881
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Matthew Kehoe	
14. MOTHER'S MAIDEN NAME Emma White		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address H. Winship Wheatley Jr University Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart failure 420.0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-4 , 19 58 , to 6-4 , 19 60 , that I last saw the deceased alive on 5-4 , 19 60 , and that death occurred at 3:24 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4404 Queensbury Rd. Riverdale Md. DATE SIGNED 6/5/60 ACTUAL SIGNATURE DOR Purdie M.D. PHYSICIAN'S NAME (Type) D. R. Purdie Riverdale Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

CERTIFICATE OF DEATH

Reg. Dist. No.

07286

7253

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dora First H. Middle Wilhelm Last		4. DATE OF DEATH June 23 19 60 Month Day Year	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kanns Dept Store		10b. KIND OF BUSINESS OR INDUSTRY Wrapper Ret.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles L. Huff		14. MOTHER'S MAIDEN NAME Mary C. Parr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577 07 3319	
17. INFORMANT Earl Burette-Son		18. ADDRESS 817-51st St. Cap. Hghts, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22 , 19 60 , to June 23 , 19 60 , that I last saw the deceased alive on June 23 , 19 60 , and that death occurred at 10:40 am , from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin M.D.		ADDRESS (Street, city or town, state) 6124 Antietam Ave DATE SIGNED 6/23/60	
PHYSICIAN'S NAME (Type) WM BRAININ		Capital Hgts Md	
22a. BURIAL, CREMATION, or other disposal (Specify) 6/27/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.Wm.Lee's Funeral Home ADDRESS 300-4th St.N.E.		24a. REC'D BY REGISTRAR JUN 27 '60 DATE	
24b. REGISTRAR'S SIGNATURE C. J. S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

27

7254

CERTIFICATE OF DEATH

Reg. Dist. No. 07287

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 H rs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. STREET ADDRESS Apt. A. Vista	
3. NAME OF DECEASED (Type or print) Joseph H. Williams		4. DATE OF DEATH June 10 19 60	
5. SEX Male	6. COLOR OR RACE W. C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-23
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Williams		14. MOTHER'S MAIDEN NAME Alice Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Richard Brown Laphan M.D.		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Left intra cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) hypertensive cardiovascular disease (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 , to 19 , that I last saw the deceased alive on 19 , and that death occurred at 3:20 pm on the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717 38th St. N.E. DATE SIGNED 6/12/60			
ACTUAL SIGNATURE George Hageage		M.D. 3717 38th St. N.E.	
PHYSICIAN'S NAME (Type) George Hageage		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-14-60	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Not Harmony Cme	22d. LOCATION (City, town, or county) (State) Shirley Rd Ext Md
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington & Son		ADDRESS 4925 Deane Ave NE	
24a. REC'D BY REGISTRAR JUN 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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